Common breathing mistakes during pushing

Why breathing during pushing matters

During the second stage of labor, the uterus contracts strongly while the baby descends through the pelvis and birth canal. The birthing person may feel an urge to bear down, rectal pressure, stretching, shaking, or a sense of intense effort. Breathing during pushing is not separate from that effort; it is part of the pressure system created by the diaphragm, abdominal wall, pelvic floor, and uterus.

In general physical exertion, a common principle is to exhale during the effort phase and inhale during the recovery phase. In birth, this translates to taking a breath as a contraction builds, then pushing while slowly releasing air, grunting, or vocalizing if that feels natural. This pattern may help prevent excessive bracing and may support more coordinated downward pressure.

However, birth is not a gym exercise. Some people are coached to hold their breath briefly for directed pushing, especially when there is a clinical reason to shorten the second stage or coordinate effort with monitoring. Others use spontaneous, open-glottis pushing, meaning the throat stays open and air is released during bearing down. Neither approach is universally best in every situation. The goal is to avoid unnecessary strain while responding to the

contraction, fetal status, maternal energy, and the guidance of the clinical team.

Mistake 1: holding the breath too long

Breath-holding during pushing is common because bearing down naturally increases intra-abdominal pressure. A short breath hold may happen reflexively. The problem is prolonged or repeated breath-holding that becomes rigid, panicked, or disconnected from the body's signals. In exercise physiology, holding the breath during heavy effort can contribute to dizziness because it alters pressure dynamics and may reduce smooth oxygen exchange. During labor, it may also increase facial, neck, shoulder, and pelvic floor tension.

A typical pattern looks like this: the contraction starts, the person inhales deeply, closes the throat tightly, curls forward, and strains silently for a long count. If this is repeated several times per contraction without enough recovery breathing, fatigue can build quickly. Some people feel lightheaded, nauseated, overheated, or frightened. Others notice that the effort goes into the face and chest rather than down through the pelvis.

A more flexible alternative is to inhale as the contraction rises, tuck the chin if that is comfortable and clinically appropriate, and bear down while slowly releasing air. This may sound like a low grunt, a sigh, or a controlled exhale. The American Pregnancy Association describes taking a big breath, tucking the chin, and bearing down while slowly releasing air or grunting, rather than stifling the breath.

If coached pushing is being used, it is reasonable to ask whether the count can be shorter, whether breaths can be added between pushes, or whether open-glottis pushing could be tried. The birth team can help adapt the method to maternal stamina and fetal monitoring.

Mistake 2: inhaling during the hardest effort

Another common pattern is inhaling while trying to push. During ordinary exertion, inhaling during the hardest pushing or lifting phase can make the movement feel less stable and may compress or restrict the diaphragm's role in pressure regulation. In birth, a sudden inhale during the bearing-down phase

may lift the rib cage and pull effort upward, especially if the person is anxious or trying to escape the intensity of the contraction.

This does not mean every inhale during a contraction is wrong. People need air, and pushing often occurs in several waves within one contraction. The issue is repeatedly inhaling at the exact moment the body needs coordinated downward pressure. For many people, it is easier to use the inhale to prepare and the exhale to push.

A practical rhythm might be: inhale as the contraction begins, exhale or grunt while bearing down, pause for a small recovery breath, then repeat if the contraction continues. Some people prefer several shorter pushes rather than one long push. Others feel a strong fetal ejection reflex and breathe or vocalize while the body pushes involuntarily. Both patterns can be normal, but if the effort feels scattered or ineffective, the breath may be one place to adjust.

This is also where breathing during pushing overlaps with body position. A curled position may help some people direct effort, while others breathe better upright, side-lying, kneeling, or on hands and knees. If inhalation feels trapped high in the chest, changing position may help restore diaphragmatic movement.

Mistake 3: shallow upper-chest breathing between pushes

The moments between pushes are not wasted time. They are recovery intervals, even when they last only seconds. Shallow upper-chest breathing in labor can develop when pain, fear, bright lights, monitoring equipment, or many voices in the room make the nervous system feel threatened. The breath becomes fast and high, the shoulders lift, the jaw clenches, and the pelvic floor may tighten.

Between pushing efforts, diaphragmatic breathing can help. Diaphragmatic breathing means allowing the lower ribs and abdomen to expand with the inhale rather than lifting only the upper chest. It does not require a dramatic belly breath, especially late in pregnancy when space is limited. The aim is to let the diaphragm move, soften the upper body, and give the brain a steady signal that oxygen is available.

Useful recovery cues include:

Let the jaw drop or keep the lips soft.
Release the shoulders away from the ears.
Take one slow inhale through the nose or mouth, whichever is easier.
Exhale audibly, as if fogging a mirror or making a low sigh.
Let the pelvic floor soften before the next contraction builds.

These cues are not a substitute for medical support, but they can be simple anchors when labor feels chaotic. If dizziness, tingling around the mouth, visual changes, or severe shortness of breath occurs, the birth team should be told immediately.

Mistake 4: closing the throat and clenching the jaw

The throat, jaw, diaphragm, abdominal wall, and pelvic floor are functionally connected through fascial, muscular, and neurologic patterns. Many childbirth educators use the phrase "loose lips, loose pelvis" because clenching the jaw often accompanies tightening elsewhere. Although the phrase is informal, the clinical observation is familiar: when a person clamps the mouth shut and strains silently, the pelvic floor may resist rather than yield.

Closed-glottis pushing means the throat is closed while bearing down, similar to a Valsalva-like maneuver. It can generate strong pressure. In some clinical scenarios, directed closed-glottis pushing may be used deliberately. But when it becomes the default for every push, especially without adequate breaths, it can feel harsh and exhausting.

Open-glottis pushing keeps the airway open. The person may exhale slowly, moan in a low tone, grunt, or make short sounds while pushing. Low sounds usually allow better downward pressure than high-pitched sounds, which often reflect fear and upper-body tension. The goal is not to perform a beautiful breathing technique. The goal is to keep the outlet soft enough for descent while still generating effort.

If the perineum is stretching intensely, the team may ask for gentler breathing, panting, or small grunts to slow the birth of the head. This is not failure; it is a protective adjustment that may help tissues accommodate.

Perineal support during birth, maternal position, fetal size and position, and tissue elasticity all matter, so breathing is only one part of the picture.

Mistake 5: pushing without relaxing the pelvic floor

Many people assume pushing means squeezing every muscle as hard as possible. In reality, effective pushing requires a paradox: the abdominal wall and uterus generate pressure, while the pelvic floor and perineum must lengthen and release. If the pelvic floor contracts upward at the same time the person is trying to bear down, the effort may feel blocked.

This can happen when someone is frightened of tearing, overwhelmed by the sensation of crowning, embarrassed about bowel-like pressure, or unsure what the pushing urge should feel like. It can also occur in people with pelvic floor overactivity, a history of pelvic pain, previous trauma, or high athletic bracing patterns. A pelvic health physical therapist may help some pregnant people learn the difference between contracting and relaxing the pelvic floor before birth, but individualized assessment is important.

During pushing, breath can cue release. A long exhale, open mouth, low sound, or gentle grunt may help the pelvic floor move downward. Some people imagine widening the sitting bones, releasing the anus, or sending the breath toward the baby. These are imagery cues, not anatomical commands, but they can be useful when the body needs direction.

It is also important not to force pushing before full dilation or before the team confirms that it is appropriate. Bearing down against an incompletely dilated cervix may increase swelling and fatigue. If there is an involuntary urge to push before confirmation, the team may coach panting, blowing, or side-lying positions until it is safe to proceed.

Mistake 6: ignoring posture and position

Breathing mechanics are strongly affected by posture. Slouching, collapsing the chest, or pulling the shoulders tightly forward can restrict rib movement and make diaphragmatic breathing harder. During pushing, this may occur in a semi-reclined bed position if the person is pulling hard on their legs while the neck and shoulders strain. For some, that position works well; for others,

it traps the breath and directs pressure upward.

Position changes can improve both oxygenation and pushing mechanics. Side-lying may reduce fatigue and allow the pelvis to open asymmetrically. Upright positions use gravity but may be tiring. Hands-and-knees can help some people with back labor or fetal malposition. Supported squatting can create space but may not be suitable for everyone, especially with certain anesthesia levels, monitoring needs, or blood pressure concerns.

The key is not to chase an ideal birth position. It is to notice whether the current position allows air in, air out, and downward effort. If the breath feels stuck, the person feels dizzy, or the shoulders and throat are doing most of the work, a small adjustment may help: raising the head of the bed, lowering the legs briefly, turning to the side, relaxing the grip, or changing where support people place their hands.

Any position change should be coordinated with the clinical team, particularly with epidural anesthesia, fetal monitoring, intravenous lines, ruptured membranes, or concerns about fetal heart rate.

How to prepare without overtraining the breath

Preparation should make breathing feel familiar, not rigid. Labor rarely follows a script, and the best technique may change from early labor to transition to the second stage of labor. Practicing a few adaptable patterns is more useful than memorizing one perfect method.

Consider discussing these options during prenatal care or childbirth education:

Spontaneous pushing: following the body’s urge while breathing or vocalizing naturally.
Open-glottis pushing: bearing down while slowly releasing air or making low sounds.
Shorter coached pushes: using direction from the team but avoiding overly long breath holds.
Recovery breathing between contractions: deliberately relaxing the jaw, shoulders, and pelvic floor.
Gentle crowning breaths: panting, sighing, or easing off when the team asks for

slower delivery.

People with asthma, cardiac conditions, hypertensive disorders, significant anemia, neuromuscular conditions, prior birth complications, or a planned assisted vaginal birth should ask their clinician whether any breathing or pushing approach is preferred. The same is true if regional anesthesia is planned, because sensation and pushing urge may differ.

A supportive birth environment also matters. One calm voice, clear instructions, and permission to make sound can reduce panic. Partners and doulas can help by reminding the birthing person to unclench the jaw, take a recovery breath, sip fluids if allowed, and ask questions when instructions feel confusing.