## Common experiences during pushing

### The pushing stage is variable, not scripted

The pushing stage of labor, also called the second stage of labor, begins when the cervix is fully dilated and the baby is moving down through the pelvis. Although birth education often describes this phase in a neat sequence, lived experience is much less uniform. Some people describe an unmistakable downward force and an involuntary need to bear down. Others feel pressure without a clear urge, especially if descent is slow or if epidural anesthesia reduces sensation. A few feel confused by the transition because the contractions may change character before anyone says it is time to push.

Medically, this stage includes both passive descent and active pushing. During passive descent, contractions and uterine pressure continue to move the baby lower, sometimes while the birthing person rests or waits for a stronger urge. Active pushing in labor usually involves coordinated bearing down with contractions, either directed by the body, coached by clinicians, or some combination of both. These patterns are not moral achievements or failures. They reflect anatomy, fetal position, analgesia, contraction strength, maternal energy, and the clinical situation.

Research that included interviews and videotaped births has shown wide

variation in reported second-stage sensations, including relief, pain, pressure, stretching, effort, and sometimes no urge to push. That range is important because it helps normalize many experiences while still leaving room for clinical judgment. A person can have a normal birth and feel powerful, frightened, focused, detached, vocal, quiet, or all of these in sequence.

**Pressure, fullness, and the urge to bear down**

One of the most common sensations during pushing is deep pelvic pressure. Many people describe it as intense rectal pressure, a bowel-movement sensation, or an overwhelming fullness low in the pelvis. This happens because the fetal head descends through the birth canal and compresses pelvic floor tissues, the rectum, and nearby nerves. The feeling can be startling, especially for someone who was expecting pain but not such a strong sensation of needing to open or empty the bowel.

The urge to push may feel involuntary, as if the body is bearing down without conscious decision. This is sometimes called the fetal ejection reflex, although in real labor the pattern can be partial, intermittent, or influenced by environment and interventions. Some people find the urge reassuring because it gives them a clear task and rhythm. Others find it frightening because the pressure feels larger than anything they have experienced before.

Not everyone has a strong urge right away. With an epidural, sensation may be muted, and the team may use contraction timing, fetal station, maternal feedback, or visible descent to guide pushing. In other cases, the baby may still be relatively high at full dilation, so the person may rest before active pushing begins. If the urge to push comes before full dilation, the clinical team may suggest position changes, breathing, or other strategies to reduce cervical swelling and protect tissues. The safest response depends on the examination and fetal status, so it should be guided by the maternity team.

**Pain, stretching, burning, and crowning**

As the baby descends, sensations often shift from internal pressure to stretching at the vaginal opening and perineum. The perineum is the tissue between the vaginal opening and anus, and it stretches significantly as the head emerges. Many people describe crowning as a burning, stinging, or

ring-of-fire sensation. It can be brief or prolonged, and it may come and go as the head advances with contractions and recedes slightly between them.

This burning does not automatically mean tearing is occurring. It reflects rapid stretching, nerve stimulation, and tissue tension. Clinicians may encourage slower, controlled pushing or gentle crowning breaths when the head is emerging, particularly if a slower birth of the head may help the tissues accommodate. Perineal support during birth, warm compresses, position changes, and communication about when to push or pause may be used depending on the setting and clinician practice.

Pain during pushing can also be felt in the hips, sacrum, lower back, pubic bone, thighs, or abdomen. Back pressure may be more prominent if the baby is in an occiput posterior position, sometimes called sunny-side-up, where the back of the baby's head is toward the mother's spine. Pain intensity does not reliably predict whether labor is progressing well, so assessment should include fetal position, descent, contractions, maternal condition, and fetal monitoring rather than sensation alone.

**Breathing, effort, and whole-body responses**

Pushing is a full-body effort, even when the uterus is doing much of the work. People may curl around the contraction, grip support bars, pull on a sheet, press their feet into stirrups or the bed, or change positions to find better leverage. Some use closed-glottis pushing, which involves holding the breath while bearing down, often for a counted interval. Others use open-glottis pushing during birth, exhaling or vocalizing while pushing. The best approach is individualized and may change during the second stage based on maternal comfort, fetal status, and clinical guidance.

Common body responses include shaking, sweating, nausea, dry mouth, flushed skin, leg trembling, or a feeling of heat. These can reflect exertion, adrenaline, pain, fluid shifts, and the intensity of contractions. Vocalization is also common. Low moaning, groaning, breathy sounds, or loud cries can be part of effective coping. Silence can be equally normal. A person's sound level is not a measure of strength, control, or whether pushing is being done correctly.

Fatigue is another frequent experience. The second stage may be short, or it may last longer, especially with a first vaginal birth or epidural anesthesia. Between contractions, many people enter a brief recovery state: eyes closed, breathing slower, taking fluids or ice chips if allowed, and gathering energy for the next contraction. Recovery breathing between pushing contractions can help restore oxygenation and reduce panic, but breathing should not become a performance demand. The priority is coordinated effort, maternal safety, and fetal wellbeing.

**Emotional experiences can change quickly**

The emotional landscape of pushing can be intense and fast-moving. Some people feel relief when pushing begins because the sensations finally match an action they can take. Others feel vulnerable, exposed, frightened, angry, determined, dissociated, or deeply focused. It is common for emotions to change from contraction to contraction. A person may say they cannot continue, then push effectively with the next urge. This does not mean they are failing; it often reflects the peak intensity of second stage.

Communication during pushing can strongly influence how safe and oriented someone feels. Clear, calm instructions can be helpful when there is fetal monitoring concern, epidural-related numbness, or uncertainty about timing. However, some people prefer fewer voices and more space to follow body cues. A partner, doula, midwife, nurse, or physician may help by repeating the most important information, offering position support, cooling the forehead, giving sips if appropriate, and protecting the birthing person’s preferences when the situation allows.

It is also common to feel self-conscious about bowel movements, fluids, sounds, or the visibility of the genital area. Birth teams expect these normal physiologic events. Stool may pass because the baby’s head compresses the rectum during descent. Amniotic fluid, blood-tinged mucus, urine leakage, and vaginal discharge can also appear. These are managed routinely by clinicians and do not require apology.

**How epidural anesthesia may change pushing**

Pushing with epidural anesthesia can feel different from unmedicated pushing.

An epidural may reduce contraction pain while leaving pressure, touch, or movement sensations. In some cases, it also reduces the urge to push, making it harder to identify contractions or direct effort. This is why coached pushing with epidural anesthesia may involve verbal timing from a nurse or midwife, watching the contraction pattern on a monitor, or placing hands where the person can feel abdominal tightening.

Some people with an epidural still feel strong rectal pressure or pain as the baby descends. Others feel mostly numbness and pressure. Neither experience means the epidural has succeeded or failed in a simple way; neuraxial analgesia varies by dose, placement, labor stage, and individual anatomy. If pain becomes severe, one-sided, or suddenly different, it should be reported so the anesthesia and maternity teams can evaluate it.

Epidural use may also influence positions. Depending on leg strength and local practice, pushing may occur semi-reclined, side-lying, supported upright, or with a peanut ball between contractions. Mobility restrictions should be balanced with the goal of helping the pelvis open and supporting effective descent. Any position that causes dizziness, shortness of breath, marked numbness, or fetal heart rate concern needs reassessment.

**When pushing needs extra attention**

Many intense sensations during pushing are normal, but some situations require prompt clinical attention. Persistent severe pain between contractions, sudden sharp pain, heavy bleeding, fever, faintness, chest pain, difficulty breathing, or a major change in consciousness should be assessed urgently. Concerns about fetal heart rate, stalled descent, maternal exhaustion, shoulder dystocia risk, or suspected malposition may lead the team to recommend position changes, rest, operative vaginal birth, cesarean birth, or other interventions depending on the full clinical picture.

It is appropriate to ask what is happening, what options exist, and whether there is time to decide. In urgent circumstances, recommendations may need to be made quickly, but the birthing person still deserves clear communication whenever possible. Questions such as "Is the baby tolerating pushing?", "Is the baby moving down?", and "What are you recommending and why?" can help clarify the situation.

After the baby is born, sensations often shift again: relief, shaking, tenderness, burning, uterine cramping, or emotional overwhelm may appear. The second stage ends with birth, but care continues with assessment for bleeding, perineal injury, uterine tone, newborn transition, and, when possible, immediate skin-to-skin contact. The pushing experience may take time to process, especially if it felt frightening or different from expectations. Discussing it later with a clinician, midwife, doula, or mental health professional can help put events into context.