Common problems during pushing

Why pushing sometimes becomes difficult

There is a useful difference between a hard pushing stage and a problematic one. Hard work is expected; a true problem is when contractions are no longer translating into descent, or when the person pushing is becoming too exhausted to continue safely. A broader pushing stage and delivery overview helps separate normal variation from a true stall.

Common contributors include maternal fatigue, pain, fear, dehydration, nausea, and the simple fact that labor has been long already. The uterus may still be contracting well, but the pushing effort can become poorly timed or too brief to move the baby down. In other cases, the baby is not ideally aligned in the pelvis, so the force is being applied in the wrong direction.

It also matters whether the cervix is truly fully dilated, whether the bladder is full, and whether the birth environment is helping the person focus. These are not small details. They change mechanics. A calm, systematic check of the situation is often more useful than asking for more effort.

Fatigue, breathing, and loss of coordination

One of the most common reasons pushing feels ineffective is simple exhaustion. The second stage can be physically intense, and by the time active pushing starts, the birthing person may already have spent many hours contracting, bracing, or coping with pain. Fatigue can shorten each push, reduce the ability to bear down effectively, and make it harder to recover between contractions.

A review of Breathing techniques for pushing can help when coordination slips under fatigue. Some people hold their breath too long, lose rhythm with the contraction, or tense the face, throat, and pelvic floor at the same time. Others become so overwhelmed that they cannot find a consistent pattern at all. The result is not a failure of will; it is a mismatch between physical demand and available energy.

People with epidurals may push differently, and that is expected. Sensation can be reduced, so guidance may focus more on timing, rest, and body positioning than on force. If pushing becomes unproductive, the team may pause to let the person recover rather than continuing a long stretch of ineffective effort.

Shallow, hurried pushes that fade before the contraction ends.
Breath-holding that causes panic or dizziness.
Visible shaking, trembling, or inability to rest between contractions.
Confusion about when to push because sensation is muted or inconsistent.

Position, pelvic space, and fetal alignment

Pushing is not only about force. It is also about geometry. The Best positions for pushing stage are the ones that improve comfort, pelvic opening, and fetal descent. Upright, side-lying, hands-and-knees, squatting, and supported kneeling positions can each help in different situations. What matters is whether the position improves the angle of descent and whether the person can sustain it.

Fetal malposition is a frequent reason descent slows. A baby who is occiput posterior, deflexed, or otherwise not well aligned may press against the pelvis in a way that makes progress inefficient and can increase back pain or the feeling of being stuck. Sometimes the issue is a full bladder, which physically narrows available space and can make the presenting part less able to descend.

Pelvic mismatch is a more serious concept, but it should be used carefully. Not every slow pushing stage means the pelvis is too small. Labor is dynamic, and babies can rotate and descend over time. Still, when position changes, bladder emptying, and rest do not improve progress, the team should reassess rather than assume that more pushing alone will solve the problem.

What prolonged pushing can mean

When pushing goes on for a long time without clear descent, the clinical picture changes. The risk is not just discomfort. A recent systematic review found that prolonged pushing is linked with higher maternal morbidity, including cesarean delivery, transfusion, perineal laceration, chorioamnionitis, and postpartum hemorrhage. It also found neonatal effects, including higher NICU admission, and in nulliparous patients, a higher risk of low 5-minute Apgar score when pushing exceeds 60 minutes.

That does not mean every long second stage is dangerous, but it does mean duration matters. The team usually weighs progress, fetal status, maternal exhaustion, and the overall labor context. A long second stage may still end vaginally, but the balance between benefit and risk changes as time passes.

Cochrane’s review of pushing methods notes that spontaneous and directed pushing do not show clear differences for many outcomes. It also notes that delayed pushing with epidural can shorten active pushing but lengthen the second stage and may increase the risk of low umbilical cord pH. In other words, there is rarely a single best rule. Management is individualized, and the safest choice depends on what the fetus and parent are doing in real time.

Warning signs that need prompt evaluation

Some problems during pushing are expected; others are not. Heavy bleeding is never something to ignore. So is a fetal heartbeat that is persistently slow, hard to obtain, or otherwise concerning. These findings can point to fetal distress or maternal complications that need immediate assessment.

Severe or sudden abdominal pain, a sensation that something has torn, or worsening pain that does not match the contraction pattern may suggest a uterine tear or another acute problem. Fever, foul-smelling fluid, or marked

uterine tenderness can raise concern for infection such as chorioamnionitis. Prolonged pushing with no descent, especially when the person is exhausted, can also signal a problem that needs a fresh exam rather than more waiting.

In some settings, very prolonged pushing has been associated with maternal or fetal emergencies, and practical guides also mention the possibility of fistula or uterine injury when the second stage drags on unusually long. The key point is not to self-interpret these signs. It is to alert the labor team quickly so they can decide whether the issue is position, fatigue, obstruction, fetal intolerance, or something more urgent.

How clinicians may respond

When pushing is not working, the response usually starts with a reassessment, not a command to push harder. The team may confirm full dilation, check fetal position, empty the bladder, change the parent’s position, and review contraction pattern and fetal heart tracing. If the person is worn out, a short rest may be more effective than repeated coached efforts.

Depending on the situation, clinicians may encourage a different posture, adjust support for breathing and timing, or use delayed pushing in selected epidural cases. If descent is still not happening, they may discuss operative vaginal delivery or cesarean delivery when those are medically appropriate. That decision depends on the stage of labor, fetal wellbeing, pelvic exam findings, and the resources available.

Support matters here too. Calm partner support during childbirth can reduce noise, help the birthing person stay oriented, and make communication with staff easier. Clear explanations help people understand why the plan is changing. If you are the birthing person or support person, it is reasonable to ask what the team thinks is causing the delay, what signs they are watching, and what the next decision point is.