Do you need to push and what it feels like

When pushing usually begins

The pushing stage of labor usually begins after full cervical dilation, commonly described as 10 centimeters. Full dilation means the cervix has opened enough that it is no longer the main barrier between the baby and the vaginal canal. Even then, the start of active pushing is not always automatic. Your care team also considers fetal station, contraction pattern, maternal condition, fetal heart rate, and whether the baby is rotating or descending effectively.

In the second stage of labor, contractions continue to move the baby down through the pelvis. Some people feel an immediate, overwhelming urge to bear down as soon as the cervix is complete. Others reach full dilation but feel pressure rather than a clear pushing reflex. In some situations, clinicians may recommend waiting briefly before active pushing, especially if the baby is still relatively high and both parent and baby are stable. This is sometimes called laboring down or delayed pushing.

The key point is that the sensation alone does not confirm that it is time to push. A strong urge can occur before the cervix is fully dilated, particularly during transition, and pushing against an incompletely dilated cervix may

increase swelling or make progress harder. If you feel pressure, shaking, nausea, or an uncontrollable need to push, tell your nurse, midwife, or doctor promptly so they can assess what is happening.

What the urge to push can feel like

The classic urge to push is often described as rectal pressure during labor. Many people say it feels like needing to have a bowel movement, sometimes urgently. This happens because the baby's head presses on the rectum, pelvic floor, and nearby nerves as it descends. The sensation may build during a contraction, peak with the contraction's intensity, and ease between contractions. For some, that pressure feels productive and directional, as if the body is trying to move the baby downward without conscious effort.

The feeling can also be more complex than simple pressure. You may notice deep pelvic fullness, stretching in the vagina, pressure in the tailbone, burning or stinging near the perineum, or a heavy downward force that is difficult to resist. During crowning, when the widest part of the baby's head stretches the vaginal opening, some people feel intense burning or a ring-like stretching sensation. Others feel numbness, pressure, or surprisingly little pain depending on anesthesia and individual nerve response.

Emotionally, the urge to push can feel both reassuring and alarming. It may be reassuring because it signals that labor is progressing. It may be alarming because the body can seem to take over. You may vocalize, grunt, hold your breath briefly, curl forward, or instinctively change position. These responses are common. Your team can help you distinguish effective downward pressure from tension in the face, shoulders, or pelvic floor that may make pushing harder.

Why you may not feel ready to push

Not everyone feels a clear pushing urge, and absence of that sensation does not necessarily mean something is wrong. Epidural anesthesia can reduce pain and blunt the sensory feedback from the pelvic floor and rectum. With a dense epidural, you may feel only pressure, vague tightening, or nothing specific during contractions. In that case, coached pushing with epidural anesthesia may be used, often guided by contraction monitoring, abdominal palpation, or instructions from the care team.

Fetal position also matters. A baby in an occiput posterior or asynclitic position may create intense back or rectal pressure without efficient descent. Conversely, a baby who remains high in the pelvis after full dilation may not generate the same strong reflex until more descent occurs. Maternal fatigue, medications, anxiety, and the speed of labor can also affect perception. Some labors move quickly from transition into birth, while others have a quieter pause before the body seems ready to bear down.

If you do not feel ready, say so. Your team may suggest position changes, rest, waiting through a few contractions, adjusting epidural dosing when appropriate, or beginning gentle coached efforts. The goal is not to perform pushing perfectly; it is to coordinate uterine contractions, abdominal effort, pelvic floor relaxation, and fetal descent while monitoring both you and the baby.

Spontaneous pushing and coached pushing

Spontaneous pushing means following your body's reflexive urge, usually bearing down when the contraction makes it feel unavoidable and resting when it fades. Many people naturally use shorter pushes, low sounds, and pauses for breath. This approach can feel intuitive, especially when sensation is intact and the baby is descending well.

Coached pushing means the care team gives more structured guidance, such as when to start, how long to push, how to position your body, or how to breathe. It may be helpful when epidural anesthesia reduces sensation, when contractions are difficult to perceive, when fatigue is significant, or when fetal heart rate patterns suggest a need for more efficient progress. Coached pushing can include closed-glottis pushing, where the breath is held briefly while bearing down, or open-glottis pushing during birth, where exhalation or low vocalization occurs during effort. Each has potential uses, and the best approach depends on the clinical situation.

Many births use a blend. You might start with rest and spontaneous pushing, then receive more coaching as the baby crowns. Near delivery, your clinician may ask you to pant, blow, or reduce force temporarily to allow slower stretching of the perineum. This is not a sign that you are doing something wrong. It is often a strategy to control the speed of birth and support the

tissues as the head emerges.

What your body is doing during a push

During a contraction in the second stage, the uterus contracts from the top downward, increasing intrauterine pressure and helping flex and move the baby through the pelvis. When you push, your diaphragm and abdominal muscles add pressure from above. Ideally, the pelvic floor lengthens and relaxes rather than bracing against the baby's descent. This coordination is why pelvic floor relaxation during birth can be just as important as force.

A useful push often feels directed downward into the pelvis, not upward into the throat or face. People commonly tuck the chin, curl around the abdomen, pull legs back, lean forward, squat, kneel, or lie side-lying depending on mobility, monitoring, anesthesia, and comfort. No single position is universally best. Upright or lateral positions may help some people feel more space or control; semi-recumbent positions may be preferred when close monitoring or clinician access is needed.

Between contractions, recovery matters. Your uterus is still doing significant work, and the baby is still being monitored. Resting your jaw, shoulders, abdomen, and pelvic floor between pushes can conserve energy. Sips of fluid, cool cloths, reassurance, and concise instructions can help when the phase feels overwhelming. If you feel panicky, lightheaded, unable to catch your breath, or disconnected from what is happening, tell the team. They can slow the coaching, adjust positioning, or reassess pain control and fetal status.

When pressure needs prompt attention

Pressure is expected in late labor, but new or severe symptoms should always be reported. Tell your care team immediately if you feel an urge to push before anyone has confirmed cervical dilation, especially if the urge is uncontrollable. They may need to check whether the cervix is complete, whether the baby is descending quickly, or whether another issue is contributing to the sensation.

Also speak up about severe continuous pain between contractions, sudden sharp abdominal pain, heavy bleeding, a sudden change in fetal movement if you are

not already on continuous monitoring, chest pain, faintness, severe headache, visual symptoms, or a sense that something feels very wrong. These symptoms do not automatically mean there is an emergency, but they deserve immediate clinical assessment.

The pushing stage and delivery are closely observed because both parent and baby can change quickly. Fetal heart rate patterns, maternal exhaustion, infection concerns, blood pressure changes, and prolonged lack of descent can all influence recommendations. Sometimes the safest plan is continued pushing with support; sometimes it may involve changing position, resting, reducing epidural density, using assisted vaginal birth, or moving toward cesarean birth. Your team should explain what they are seeing, what options exist, and how urgent the decision is.

How to work with the sensation

The most practical first step is communication. Say what you feel in concrete terms: rectal pressure, burning, back pressure, numbness, no urge, constant urge, or pressure only during contractions. These details help the team understand whether the baby may be lower, whether the epidural is masking contractions, or whether your pushing strategy needs adjustment.

When a contraction begins, some people do well by taking a steady breath, letting the pelvic floor soften, and bearing down into the pressure rather than away from it. Others need direct coaching: where to place hands, when to inhale, when to push, and when to stop. Breathing during pushing is not about a single ideal pattern. It is about maintaining oxygenation, coordinating effort, and avoiding unnecessary tension.

It is also reasonable to ask for brief explanations during the process. You can ask whether the cervix is fully dilated, whether the baby is descending, what station the baby is at, and whether pushing is currently effective. If you have a birth preference, such as spontaneous pushing, upright positioning, or minimizing directed breath-holding, share it early. Preferences matter, but they may need to adapt to fetal monitoring, anesthesia, maternal fatigue, or urgent clinical changes.