Fatigue during pushing stage

Why fatigue happens in the second stage

Fatigue during the pushing stage is not a sign of weakness. The second stage of labor is metabolically demanding: the uterus continues repeated high-intensity contractions, the pelvic floor stretches, the fetus rotates and descends, and the birthing person may be asked to coordinate abdominal pressure, breathing, positioning, and pain coping at the same time. If the first stage of labor has lasted many hours, energy reserves may already be reduced before active pushing begins.

Several physiologic factors can contribute. Sleep deprivation lowers pain tolerance and makes coordinated pushing harder. Limited oral intake, nausea, vomiting, sweating, or inadequate hydration may worsen perceived exertion. Pain activates a stress response with elevated catecholamines, which can increase muscular tension and make pushing feel less efficient. Epidural analgesia may reduce pain but can also alter the urge to push or make it harder to sense fetal descent, depending on dose, timing, and individual response.

Fatigue also has a psychological dimension. The pushing stage can be emotionally intense because the end is near but not always predictable. A person may feel pressure to perform, worry about the baby, or become

discouraged if progress is slower than expected. Supportive communication matters: being told what is happening, what progress is being seen, and what options are available can reduce fear-driven exhaustion.

Pushing effort, timing, and energy use

Not all pushing is the same. Some people have a strong involuntary urge to bear down; others, particularly with epidural analgesia, may reach full cervical dilation before feeling much pressure. In many settings, clinicians distinguish between active pushing in labor and passive descent, often called laboring down. During laboring down, the person rests or changes position while contractions and fetal descent continue, and active bearing down is delayed until there is more pressure, a stronger urge, or a lower fetal station.

Research on delayed pushing has found that, in selected patients, waiting to push can reduce postpartum fatigue scores compared with immediate pushing. This does not mean delayed pushing is always preferable or risk-free; decisions depend on fetal status, contraction pattern, maternal condition, epidural use, parity, station, and local clinical protocols. Still, the evidence supports a practical idea: pushing should be treated as a coordinated physiologic task, not simply as a test of endurance.

Coached pushing during contractions may be useful, especially when someone cannot feel the urge to bear down or when fetal descent needs focused effort. However, prolonged breath-holding and repeated long sustained pushes can increase exhaustion. Many maternity teams now use a more individualized approach, blending coaching with spontaneous pushing in labor when appropriate. This may include pushing for shorter intervals, exhaling while bearing down, taking one contraction off to recover, or waiting until the contraction becomes stronger before pushing.

Signs fatigue is becoming clinically important

Mild to moderate tiredness is expected in the second stage of labor. Clinically important fatigue is different: it begins to interfere with safety, decision-making, effective pushing, or the ability to communicate. A person may become unable to coordinate pushing despite support, feel faint, shake uncontrollably between contractions, or become too overwhelmed to follow simple

instructions. Severe exhaustion can also amplify pain and anxiety, creating a cycle in which each contraction feels less manageable.

The clinical team also watches objective markers. Maternal pulse, blood pressure, temperature, hydration status, urine output, and level of alertness can help identify dehydration, infection, excessive blood loss, medication effects, or other problems. Fetal heart rate monitoring provides information about how the baby is tolerating labor. A tired parent with reassuring fetal status and ongoing descent is a different scenario from fatigue combined with nonreassuring fetal patterns, fever, arrest of descent, or heavy bleeding.

It is reasonable to say clearly, "I am exhausted," "I cannot push like this," or "I need a different plan." These statements are clinically relevant. They invite reassessment of position, analgesia, hydration, pushing technique, fetal station, and the expected time course. Fatigue should not be dismissed as merely emotional; it is part of the labor picture and may influence whether continued pushing, assisted vaginal birth, cesarean birth, or another intervention is discussed.

Strategies that may reduce exhaustion

Energy conservation begins before the first push. If full dilation is confirmed but the urge is weak and fetal status is reassuring, the care team may consider laboring down before pushing. Resting through contractions, dimming stimulation, using side-lying pushing position later, or adjusting epidural positioning can help some people gather strength. Small changes, such as cooling cloths, mouth care, sips of fluid when permitted, or IV fluids when clinically indicated, may improve comfort even if they do not remove fatigue completely.

During active pushing, technique matters. Many people tire quickly when they are asked to hold their breath for a count of ten three or four times with every contraction. Some benefit from open-glottis pushing, in which they exhale or make sound while bearing down. Others use shorter closed-glottis efforts when coached by the team. The best approach is the one that balances maternal oxygenation, fetal tolerance, descent, and the person’s ability to continue.

Position can also influence workload. Best positions for pushing stage vary by

anatomy, fetal position, epidural mobility, monitoring needs, and comfort. Upright positions may use gravity and pelvic mobility for some people, while side-lying may allow rest and reduce sustained leg strain. Hands-and-knees positioning can be useful when back pressure is intense or fetal rotation is being encouraged. Changing positions during pushing stage should be guided by safety, monitoring, and how the person feels, not by a single ideal posture.

Ask for brief, specific coaching rather than constant instructions.
Use rest periods between contractions deliberately: unclench the jaw, drop the shoulders, and slow breathing.
Consider changing position if pushing feels ineffective or one muscle group is failing.
Tell the team early if nausea, dizziness, panic, or pain is draining energy.

The role of support and communication

Fatigue often improves when the room becomes more organized. A supportive team can reduce cognitive load by giving simple updates: where the baby is, whether descent is occurring, how the fetal heart rate looks, and what the next few contractions are intended to accomplish. Vague encouragement may feel hollow when someone is exhausted; concrete information is usually more useful.

Support people can help by protecting rest between contractions. This may mean offering a cool cloth, holding a leg only during the contraction, helping with position changes, or reminding the birthing person to release tension afterward. It is also appropriate for a support person to say to the team, "She is becoming very tired; can we reassess the plan?" This is not adversarial. It helps bring fatigue into the clinical conversation.

For medically literate families, it can be helpful to ask targeted questions: Is there ongoing fetal descent? What is the fetal station and position? Is the fetal heart tracing reassuring? Are there reasons to push now rather than rest for a few contractions? Would a different position, bladder emptying, analgesia adjustment, or obstetric assessment change the situation? These questions do not replace medical judgment, but they support shared decision-making when exhaustion is rising.

Recovery after a fatiguing pushing stage

Fatigue during the second stage can extend into the early postpartum period. After birth, the body must continue uterine contraction to reduce bleeding, begin lactation physiology if breastfeeding is planned, recover from fluid shifts, and process an intense physical event. A person who pushed for a long time may also have muscle soreness in the abdomen, back, legs, pelvic floor, jaw, or shoulders, especially after prolonged coached pushing or sustained positions.

Postpartum fatigue is not only about sleep. Blood loss, anemia, infection, pain, perineal trauma, operative birth, emotional distress, and feeding demands can all contribute. If exhaustion feels extreme, worsens rather than gradually improves, or comes with shortness of breath, chest pain, fainting, fever, heavy bleeding, severe headache, confusion, or thoughts of self-harm, urgent medical care is needed.

In the first days after birth, recovery is often supported by practical measures: adequate pain control recommended by a clinician, hydration, iron evaluation when indicated, help with infant care, and protected sleep blocks. It can also be emotionally important to debrief the birth. If the pushing stage felt frightening or out of control, discussing what happened with a midwife, obstetric clinician, nurse, doula, or mental health professional may help make sense of the experience.