How long the pushing stage lasts

What counts as the pushing stage?

The pushing stage is commonly used to describe the active part of the second stage of labor, when the cervix is fully dilated and the birthing person is bearing down with contractions to help the baby move through the birth canal. More precisely, the second stage of labor begins when full cervical dilation is confirmed and ends when the baby is born. Within that interval, there may be a passive phase, sometimes called laboring down, before active pushing starts.

This distinction matters because not everyone begins pushing the moment they reach 10 centimeters. Some people feel an overwhelming, spontaneous urge to push right away. Others, especially with epidural analgesia, may feel pressure but not a clear urge. In that situation, the care team may recommend waiting while contractions continue to move the baby lower, as long as fetal and maternal status remain reassuring.

So when someone asks how long the pushing stage lasts, the answer depends on what is being measured: the total second stage of labor, the period of active pushing, or the final minutes when the baby crowns and is born. In clinical practice, all three can be relevant, but active pushing time is often what families remember most vividly.

Typical duration for a first baby

For a first vaginal birth, pushing is usually longer than it is for someone who has given birth vaginally before. Sutter Health notes that first-time mothers often push for about 1 to 2 hours, though it can take longer. The NHS states that for a first baby, the pushing stage should generally last no longer than 3 hours.

These numbers are helpful reference points, not personal deadlines. A first birth involves tissues, pelvic floor muscles, and maternal pushing coordination that have not previously gone through vaginal delivery. The baby may also need time to flex, rotate, and descend through the pelvis. Progress may happen gradually: a small change in fetal station, increased pressure, or more visible stretching of the perineum can all indicate that labor is moving forward even when birth is not imminent.

Clinicians usually consider several questions rather than focusing only on elapsed time: Is the baby descending? Is the fetal heart rate reassuring? Is the birthing person coping physically? Are contractions strong and frequent enough? Is there swelling, fever, bleeding, or exhaustion? A longer first pushing stage can still be within normal variation when progress is present and monitoring is reassuring.

Typical duration after a previous vaginal birth

For someone who has had a previous vaginal birth, the pushing stage is often shorter. The NHS describes a usual upper limit of about 2 hours for people who have given birth before. Many subsequent births involve far less active pushing, sometimes only a few contractions, because the tissues and pelvic floor have stretched before and the baby may descend more efficiently.

Still, previous birth does not guarantee a quick second stage. A larger baby, malposition, epidural effects, a less effective contraction pattern, maternal fatigue, or a long first stage can all slow progress. Conversely, some multiparous people experience a very rapid second stage, which can feel overwhelming because the body may push powerfully and involuntarily.

Because rapid birth and prolonged pushing carry different challenges, individualized support matters. In a fast second stage, the focus may be controlled breathing, perineal support during birth, and helping the baby emerge steadily. In a longer second stage, the focus may be position changes, rest, hydration as appropriate, bladder emptying, and reassessment of fetal station in labor.

How an epidural can change timing

Epidural analgesia can be very helpful for pain relief, but it can also change the sensations that guide pushing. Some people with an epidural feel pressure and an urge to bear down; others feel little or no urge even when fully dilated. The NHS notes that an epidural may make the urge to push less noticeable, and research discussions on pushing practices have described delayed pushing as an option when the urge is absent.

Delayed pushing, often called laboring down or passive descent during labor, means waiting after full dilation while contractions move the baby lower before active pushing begins. One evidence-based approach described in the literature allows delayed pushing for up to about 2 hours in nulliparous women with epidural anesthesia and up to about 1 hour in multiparous women with epidural anesthesia, while emphasizing that pushing should be guided by the urge when possible.

The goal is not to make labor longer for its own sake. The purpose is to reduce ineffective pushing when the baby is still high and to conserve energy until pushing is more productive. However, delayed pushing is only appropriate when the clinical picture supports it. The care team will monitor fetal heart rate, contraction pattern, maternal temperature, bleeding, pain, and descent. If there are concerns, they may recommend active pushing sooner or consider other options.

Why fetal position and descent matter so much

The baby’s position strongly influences how long pushing lasts. An occiput anterior position, in which the back of the baby’s head is toward the front of the pelvis, often fits the pelvic curve more efficiently. A posterior position, sometimes described as the baby facing upward toward the birthing person’s

abdomen, can make descent and rotation more difficult. Sutter Health specifically notes that pushing may take longer when the baby is in a posterior position.

Fetal station is another key measure. It describes how low the presenting part of the baby is in relation to the ischial spines of the pelvis. A baby who is already low at full dilation may be born relatively quickly. A baby who remains high may need more time, more rotation, or additional assessment before active pushing becomes effective.

During the second stage of labor, the baby performs a series of movements: flexion of the head, descent, internal rotation, extension under the pubic arch, restitution, and birth of the shoulders and body. These cardinal movements of labor are not always visible from the outside, but they are central to progress. If the baby is not rotating or descending despite strong contractions and effective pushing, the team may reassess position, pelvic fit, and options for support.

What can make pushing shorter or longer?

Several factors influence pushing stage duration, and many are not under the birthing person’s conscious control. It can be reassuring to know that a longer pushing stage is not a sign of failure. Birth is a physiologic process shaped by anatomy, hormones, fetal position, pain relief, fatigue, and clinical circumstances.

Factors that may affect duration include:

Parity: first vaginal births typically involve longer pushing than later vaginal births.
Epidural density: a dense block may reduce motor strength or awareness of pressure, while a lighter block may allow more sensation and movement.
Fetal position: posterior or asynclitic positions can slow descent.
Contraction quality: contractions that are widely spaced or less forceful may produce slower progress.
Maternal energy: dehydration, sleep deprivation, prolonged labor, nausea, or anxiety can make sustained pushing harder.
Bladder fullness: a full bladder can sometimes interfere with descent,

especially with epidural analgesia.
Positioning: upright, side-lying, hands-and-knees, semi-recumbent, or supported squat positions may affect pelvic dimensions and comfort differently.

Because these variables interact, the best pushing approach is usually individualized. Some people benefit from coached pushing with breath-holding for short intervals; others do better with spontaneous pushing, exhaling or making low sounds during contractions. The safest method depends on maternal comfort, fetal status, epidural effect, and the care setting.

When a longer pushing stage needs extra attention

A pushing stage that is longer than average does not automatically mean something is wrong. However, prolonged pushing deserves careful, repeated assessment. The key clinical question is whether labor is still progressing and whether parent and baby are tolerating it well.

Your care team may become more concerned if there is minimal or no descent over time, worsening fetal heart rate patterns, maternal fever, heavy bleeding, severe exhaustion, rising blood pressure, suspected infection, or signs that contractions are not adequate. They may also reassess if the baby’s head is not rotating, if significant swelling develops, or if the birthing person can no longer push effectively.

Possible next steps depend on the situation and may include position changes, adjusting epidural dosing, allowing rest, emptying the bladder, evaluating contraction strength, or discussing assisted vaginal birth with vacuum or forceps if criteria are met. In some situations, cesarean birth may be recommended. These decisions are highly individualized and should be made with a qualified obstetric or midwifery team who can explain the benefits, risks, and alternatives in real time.

Coping emotionally and physically while pushing

Even when everything is medically reassuring, a long pushing stage can be draining. It is common to feel discouraged if progress is slow or if people in the room keep saying the baby is "almost there" for longer than expected. Supportive, specific communication can help: ask what has changed since the

last assessment, whether the baby is lower, and what the next goal is.

Between contractions, rest as completely as possible. Relax the jaw, shoulders, hands, and pelvic floor if you can. If allowed, small sips of fluid, cool cloths, position changes, and steady reassurance may help preserve energy. A support person can be useful by repeating instructions, holding a leg only if desired, helping with breathing rhythm, and reminding you that slow progress is still progress.

It is also reasonable to ask for a pause in coached pushing if you are exhausted and the clinical situation allows it. Some people need a few contractions to breathe through, reset, or wait for stronger pressure. Others find that a change to side-lying or upright positioning improves comfort and effectiveness. The most supportive approach is one that respects both physiologic birth and medical safety.