

How pushing problems are managed



What clinicians mean by pushing problems

In birth, pushing problems usually refer to difficulty moving the baby down and out during the second stage of labor, after full cervical dilation. This does not mean the birthing person is doing anything wrong. Pushing depends on several coordinated factors: uterine contractions, maternal effort, pelvic anatomy, fetal position, fetal size, pain control, pelvic floor relaxation, and the ability to recover between contractions.

Common patterns include an absent or weak urge to push, ineffective bearing down, severe exhaustion, intense fear or loss of focus, pain that prevents coordinated effort, or slow descent despite strong contractions. With epidural anesthesia, the urge to push may be reduced, and some people need more coaching or time for passive descent. Without epidural anesthesia, the urge may be powerful but hard to coordinate if contractions are overwhelming.

Clinicians generally manage pushing problems by identifying the most likely limiting factor. A baby who is high in the pelvis is managed differently from a baby who is low but rotating slowly. A person who is exhausted may need rest and fluids, while someone whose pelvic floor is tightening reflexively may need breathing, position changes, and calm coaching. The goal is not perfect

performance; it is safe progress for parent and baby.

Assessment before changing the plan

Management begins with a structured assessment. The care team evaluates maternal vital signs, pain, hydration, bladder fullness, contraction frequency, fetal heart rate patterns, cervical dilation confirmation, fetal station, and fetal position when this can be assessed. They also look at whether the baby descends during contractions and whether the descent is sustained between pushes.

Bladder fullness can sometimes reduce pelvic space, so clinicians may address this, especially when an epidural limits the ability to urinate. If contractions have spaced out or weakened, the team may evaluate whether uterine activity is adequate. If pain is disrupting pushing, anesthesia support may be considered. If the birthing person is pushing well but the baby is not descending, the team may reassess fetal position, including whether the baby is occiput posterior, asynclitic, or not well flexed.

The fetal heart rate tracing matters. If the baby appears well and the birthing person is coping, there may be time to adjust technique and allow descent. If there are concerning fetal heart rate changes, heavy bleeding, infection concerns, or maternal instability, the threshold for intervention becomes lower. This is why two labors that look similar from the outside may be managed differently.

Timing, rest, and delayed pushing

Not everyone needs to start active pushing immediately after full dilation. If the baby is still relatively high, especially with an epidural, clinicians may suggest a period of passive descent, sometimes called laboring down. During this time, contractions continue to move the baby lower while the birthing person rests. This approach is individualized and depends on maternal status, fetal monitoring, labor progress, and local clinical protocols.

Rest can be a medical intervention in its own right. Exhaustion makes it harder to coordinate abdominal pressure, relax the pelvic floor, and respond to coaching. Short periods of side-lying rest, quiet breathing, hydration support,

or changes in lighting and stimulation may help a person regain enough capacity to push effectively. If nausea, shaking, or panic is present, the team may first focus on stabilizing breathing and comfort.

Delayed pushing is not appropriate in every situation. If fetal monitoring is concerning or birth appears imminent, active pushing or another intervention may be safer. The decision is clinical, not moral. A person who needs rest is not failing, and a person who needs faster action is not being rushed without reason; the team is balancing time, progress, and safety.

Coaching breathing and bearing down

Pushing is partly muscular and partly neurological. The diaphragm, abdominal wall, uterus, and pelvic floor all need to work in a coordinated direction. Some people respond well to instinctive, open-glottis pushing, where they exhale or vocalize while bearing down. Others, particularly with dense epidural anesthesia, may need coached pushing guidance to understand when and where to direct effort.

Common adjustments include waiting until the contraction builds before pushing, curling around the baby rather than lifting the shoulders tensely, releasing the jaw and throat, and directing pressure downward rather than into the face. Clinicians may use simple cues such as breathing in, bearing down toward the rectum, then fully releasing between efforts. The release between pushes matters because constant bracing can make pelvic floor muscles resist descent.

Breath-holding during pushing is sometimes used briefly in coached settings, but prolonged or forceful breath-holding can increase fatigue and may not suit every person. The care team may modify the approach if the fetal heart rate changes, if the birthing person feels lightheaded, or if pushing becomes chaotic. Breathing techniques for pushing are tools, not tests of discipline. The best method is the one that supports descent while preserving safety and stamina.

Position changes and pelvic floor release

Positioning is one of the most practical ways to manage pushing problems. Different positions change pelvic diameters, pressure on the sacrum, and the

direction of maternal force. Side-lying, semi-sitting, hands-and-knees, supported squat, kneeling, or use of a birth bar may be considered depending on mobility, epidural strength, fetal monitoring needs, and staff support.

If the baby is rotating slowly, positions that create asymmetry, such as side-lying with one leg supported or a lunge-like posture, may be used when clinically appropriate. If the birthing person has back pain or an occiput posterior fetal position is suspected, hands-and-knees or forward-leaning positions may be discussed. With an epidural, position changes often require hands-on assistance to protect numb legs and prevent falls.

Pelvic floor relaxation during birth is as important as abdominal effort. People sometimes respond to pressure by tightening the buttocks, thighs, or perineum, which can reduce the effectiveness of a push. Warm compresses, calm verbal cues, lower vocalization, and perineal support during birth may help some people soften into the pressure. If there is severe pain, scar tissue sensitivity, prior trauma, or fear of tearing, sensitive communication is essential. Consent should remain active and specific, especially for vaginal examinations and perineal support.

When progress remains slow

If pushing continues for a prolonged period with limited descent, clinicians reassess the whole situation rather than relying on time alone. They consider parity, epidural use, fetal station, fetal position, maternal temperature, bleeding, exhaustion, contraction adequacy, and fetal heart rate. Slow progress with a reassuring baby and a stable parent may allow continued pushing, while slow progress with deterioration may require a different plan.

Possible next steps may include more targeted position changes, anesthesia adjustment, treatment of bladder distension, evaluation of contraction pattern, or discussion of operative birth. Assisted vaginal birth with vacuum or forceps may be considered when the cervix is fully dilated, the baby's head is low enough, position is known, and the clinician judges that vaginal birth can be completed safely. The risks and benefits should be explained in real time whenever circumstances allow.

Cesarean birth may be recommended if the baby is not descending, if assisted

vaginal birth is not appropriate, or if there are urgent maternal or fetal concerns. For many families, this shift can feel emotionally abrupt. Good care includes clear explanation: what has changed, what options exist, what risks are being weighed, and how the team will support the birthing person through the next step.

Bowel straining, constipation, and postpartum recovery

Some people use the phrase pushing problems to describe bowel straining during late pregnancy or after birth. This is clinically different from the second stage of labor, but the pelvic floor connection is real. Constipation, fecal impaction, hemorrhoids, perineal pain, opioid pain medicines, dehydration, reduced mobility, and fear after stitches or tearing can all make bowel movements difficult.

General constipation management often begins with adequate fluid intake, dietary fiber, movement as tolerated, and regular toileting habits. Medical reviews also describe stool softeners, osmotic laxatives, suppositories, and bowel scheduling after meals as possible components of care, depending on the person's situation. These should be discussed with a clinician or pharmacist after birth, especially when breastfeeding, recovering from surgery, taking pain medicine, or having significant rectal pain or bleeding.

Pelvic floor dysfunction can cause obstructed defecation, where a person strains but the pelvic floor does not relax effectively. In adults with dyssynergic defecation, biofeedback therapy is described as an effective treatment because it retrains coordination rather than simply forcing stool out. Bowel retraining strategies may also help some people establish predictable timing and reduce excessive straining. After birth, persistent constipation, fecal leakage, severe pain, or a sensation of blockage deserves professional assessment rather than repeated forceful pushing.