How to push during labor correctly

When pushing should begin

In routine labor, active pushing starts once the cervix is fully dilated, which is why clinicians confirm cervical exam findings and maternal readiness before they ask for bearing down. That timing matters because pushing too early can be inefficient and exhausting. In some labors, especially when contractions are irregular or the head is still relatively high, the team may recommend waiting briefly so the baby can descend on its own. This is often called a passive second stage or laboring down after full dilation.

The strongest evidence and professional guidance do not support a single rigid rule for every birth. When there is no fetal distress and the birthing person is coping well, waiting for the natural urge to push can be reasonable. If the care team is monitoring a concerning fetal heart rate pattern, if there is maternal exhaustion, or if progress has stalled, they may encourage more active pushing. The key is not to guess in isolation; it is to align your effort with the clinical picture and with the body cues you feel.

What effective pushing actually means

Correct pushing is usually a coordinated increase in intra-abdominal pressure

during a contraction, combined with pelvic floor relaxation rather than rigid bracing. Think of it as directing force downward and forward while keeping the upper body as quiet and open as possible. If you are able to feel the urge, many clinicians prefer that you respond to it rather than forcing a set number of hard pushes on command. That spontaneous style often feels more intuitive and can preserve energy.

Many people are taught to take a breath and hold it, then bear down hard for a count of several seconds. That pattern may still be used in some settings, especially if a clinician wants brief, well-timed effort. But many labor teams now emphasize a more flexible approach, often described as open-glottis pushing during birth, in which you exhale, vocalize softly, or let the breath move while you push. The practical goal is steady pressure without excessive tension. If your jaw is clenched, your shoulders are lifting, or you feel panicked, the effort is probably too forceful for effective work.

Breathing techniques for pushing are not about performing labor perfectly. They are a way to help you stay synchronized with contractions, recover between efforts, and keep oxygen delivery adequate. A simple pattern is: breathe in, let the contraction build, push while exhaling or bearing down gently, then fully recover before the next effort. If your team gives different instructions based on fetal status or stage of descent, follow those instructions. Technique should serve the labor, not the other way around.

How to use your body position well

Position can make a real mechanical difference because the pelvis is not fixed; it changes shape and available space depending on hip angle, trunk angle, and gravity. Side-lying can reduce fatigue and help if you need rest or perineal control. Sitting or semi-sitting may be useful if you want to use gravity without excessive pressure. Squatting can widen pelvic dimensions for some people, while hands-and-knees may reduce back pain and help if the baby is facing a position that makes descent harder. In FIGO guidance, comfortable, mechanically beneficial positions such as squatting or sitting are specifically noted as useful options.

There is no need to stay in one position for the entire second stage. In many births, the most effective plan is to change position based on what the

contraction pattern, fetal rotation, and maternal fatigue are doing. If a position increases pain in the back, makes you feel unstable, or leaves you unable to coordinate your breath, it is reasonable to adjust. The best position is usually the one that you can sustain long enough to push effectively while still relaxing between contractions.

If you are pushing with epidural anesthesia, position becomes even more important because sensation and proprioception may be reduced. Side-lying with support, supported sitting, or frequent changes in posture can help you find enough alignment to direct pressure without overstraining. Your team may also coach leg support, hip opening, or subtle shifts in pelvic tilt so the baby can descend more efficiently.

Pushing with epidural anesthesia or a slower second stage

With epidural analgesia, the urge to push may be muted or delayed. That does not mean the pushing is failing; it often means sensation is reduced enough that the team has to use cervical exam findings, contraction patterns, and fetal station to judge timing. In these cases, laboring down after full dilation can be helpful. The baby may descend passively while you rest, regain energy, and wait for a clearer urge to push or for the fetal head to move lower into the pelvis.

Coached bearing-down efforts may also be used when epidural medication limits spontaneous feedback. The instructions are typically simple and repetitive: take a breath, bear down with the contraction, and rest completely between contractions. If the clinician or midwife is monitoring fetal heart rate closely, they may adjust how long each push lasts, how many pushes you do per contraction, or whether they want you to pause. That is not a sign that you are doing something wrong; it reflects active management of the second stage of labor.

Some people worry that slower progress means poor pushing technique. Often it does not. Fetal position, pelvis shape, tissue elasticity, the degree of molding, contractions, and analgesia all matter. A long second stage can still end in a vaginal birth when the mother and team respond thoughtfully. The question is not whether every push looks identical, but whether the pattern is helping the baby descend safely while the birthing person remains as rested and

coordinated as possible.

How to coordinate breathing, effort, and rest

Effective pushing is a cycle of work and recovery. During the contraction, keep your face and shoulders soft if you can. Release the jaw. Let the tongue rest. Feel the pelvic floor soften rather than grip. Push in a way that feels like you are moving pressure downward, not like you are trying to lift your entire torso out of the bed. When the contraction ends, stop actively bearing down and recover fully. Recovery breathing between pushes helps restore oxygen, reduce dizziness, and prepare you for the next contraction.

A simple mental cue can help: "low effort, then complete rest." That sounds almost too plain, but it reflects the physiology. A laboring person who spends every second braced and breath-holding usually tires faster than someone who uses brief, well-timed effort and real recovery. If you notice that the push feels more like a face, neck, and shoulder effort than a pelvic effort, reset your posture, exhale, and start again on the next contraction. If you have a support person, ask them to remind you to relax your jaw and hands, because those muscle groups often mirror unwanted tension elsewhere in the body.

Some clinicians will offer gentle blowing during crowning if the fetal head is descending quickly and they want to reduce abrupt pressure on the perineum. That is a situational instruction, not a universal rule. The larger principle is to match the intensity of the push to the moment in labor. Stronger is not automatically better. Better is what moves the baby down while protecting you from unnecessary strain.

When to pause, ask for help, or change the plan

There are times when the most correct response is to slow down or revise the approach. If you become dizzy, have severe shortness of breath, lose effective coordination, or cannot recover between contractions, tell the team immediately. If the fetal heart rate pattern changes, if there is significant bleeding, or if the clinician asks you to stop bearing down, follow that direction promptly. These situations call for clinical judgment, not willpower.

It is also reasonable to ask for a technique reset when pushing feels

unproductive. The team may suggest a new position, a short break, better pain control, or a different breathing pattern. Shared decision-making in labor matters here because the second stage is dynamic. What worked five minutes ago may be wrong now. A person can go from spontaneous pushing to coached pacing, or from active pushing to a brief rest period, depending on fetal station, maternal energy, and the care plan.

If the baby is descending slowly, that does not automatically mean trouble. Some births need prolonged active pushing, while others move quickly once the head starts to rotate and pass the pelvic floor. Your job is to keep each contraction purposeful and each rest interval complete. Your team’s job is to watch the whole picture and help you adapt. Correct pushing is therefore not a single maneuver; it is a responsive process.