Pushing stage and delivery overview

What the pushing stage means

The pushing stage is the second stage of labor. It begins when the cervix has reached full cervical dilation, usually defined as 10 centimeters, and ends when the baby is born. By this point, the cervix has moved from being the main focus of labor to becoming an open passage, while the uterus, pelvic floor, maternal effort, and fetal positioning work together to complete birth.

Clinically, the second stage of labor has two overlapping parts. The first is descent: the baby continues to rotate and move lower through the pelvis. The second is expulsive effort: contractions and pushing help the baby's head and body emerge. Some people feel an unmistakable pressure or urge to bear down immediately after full dilation. Others, especially with an epidural, may feel little or no urge at first.

This stage often feels different from the first stage of labor. Contractions may remain intense, but the experience can shift from coping with dilation to actively working with the body. Many people describe rectal pressure, pelvic stretching, shaking, nausea, vocalizing, or a sensation similar to needing a bowel movement. These sensations can be normal, but new severe pain, heavy bleeding, fever, or concerns about fetal movement should always be assessed

promptly by the maternity team.

How long pushing may take

The length of the pushing stage varies widely. It may be brief, particularly for someone who has given birth vaginally before, or it may take longer for a first vaginal birth. Epidural analgesia, fetal position, maternal fatigue, contraction strength, pelvic anatomy, and the baby's station all influence timing. A longer second stage does not automatically mean something is wrong, but it usually leads to closer assessment.

Health professionals evaluate progress by considering several factors together, not by the clock alone. They may assess how low the baby is in the pelvis, whether the head is rotating, how frequently contractions occur, how the fetal heart rate responds, and how the birthing person is coping. If progress is steady and mother and baby are well, continued pushing or rest may be appropriate. If progress stalls or monitoring becomes concerning, the team may discuss options.

It can be emotionally difficult when pushing takes longer than expected. Many people imagine that once they are fully dilated, delivery will happen quickly. In reality, the baby often still has important internal movements to complete, sometimes called the cardinal movements of labor. These include flexion, descent, internal rotation, extension, and external rotation. Understanding this can make a prolonged but safe pushing stage feel less like failure and more like physiology unfolding at its own pace.

Spontaneous, directed, and delayed pushing

Pushing is not a single technique. Several approaches may be used, and the best choice depends on clinical context and personal preference. Spontaneous pushing means following the body's urge, often with shorter pushes and breathing between efforts. Directed pushing usually means a clinician or midwife coaches the person to take a breath, hold it, and push for a set count during a contraction. Delayed pushing, sometimes called laboring down, means waiting after full dilation before actively pushing, often to allow passive descent when an epidural reduces the urge.

Research comparing pushing approaches has not shown one method to be universally superior for every birth. Evidence has examined outcomes such as duration of the second stage, spontaneous vaginal birth, perineal trauma, and newborn measures. In practice, many teams use a flexible approach: allowing spontaneous effort when fetal status is reassuring, offering coaching when the person wants guidance or progress slows, and considering delayed pushing when the baby is high and there is no strong urge.

Breath-holding pushing, sometimes called closed-glottis pushing or Valsalva pushing, can produce strong downward force. Open-glottis pushing allows exhalation or sound while bearing down. Some people naturally alternate between these patterns. If fetal heart rate changes occur, if the parent becomes exhausted, or if pushing is ineffective, the team may adjust the method. It is reasonable to ask, "Can I follow my urge?" or "Can you coach me through this contraction?" Collaborative communication often makes the stage feel safer and more manageable.

Positions and support during delivery

Pushing position can influence comfort, pelvic dimensions, perineal stretching, and the ability to use gravity. Common positions include semi-recumbent, side-lying, upright kneeling, hands-and-knees, squatting with support, or using a birth bar. With an epidural, mobility may be limited, but many variations are still possible with staff assistance, such as side-lying, supported sitting, or a modified squat.

No single position is ideal for everyone. A person with severe back pressure may prefer hands-and-knees or side-lying. Someone who feels exhausted may benefit from supported semi-sitting. A team may recommend position changes if the baby’s head needs time to rotate, if the fetal heart tracing changes, or if perineal stretching needs to be slowed as the head crowns.

Support during pushing is both physical and emotional. A midwife, nurse, obstetrician, partner, doula, or birth companion may help with leg support, cool cloths, hydration, position changes, and calm reminders. Supportive language matters: many people push more effectively when they feel encouraged rather than rushed. If the room becomes busy, it is appropriate for the team to explain what is happening in clear, concise terms whenever possible.

As the baby crowns, the perineum stretches significantly. Clinicians may use warm compresses, hands-on perineal support, or controlled guidance of the head depending on local practice and the situation. The aim is not to eliminate all tearing, which is not always possible, but to support a careful birth and reduce avoidable trauma when feasible.

Monitoring progress and when assistance may be discussed

During the pushing stage, the maternity team monitors both maternal and fetal wellbeing. Maternal assessment may include blood pressure, pulse, temperature, pain control, bladder fullness, bleeding, energy level, and signs of infection or exhaustion. Fetal assessment may include intermittent auscultation or continuous electronic fetal monitoring, depending on risk factors and the labor setting.

If pushing is effective, the baby’s head usually descends over time, even if progress is gradual. Clinicians may describe station, which indicates how low the presenting part is relative to the ischial spines of the pelvis. They may also note position, such as occiput anterior, occiput posterior, or transverse. These terms help the team understand whether the baby is well aligned for birth.

Assisted vaginal birth may be discussed if there is concerning fetal heart rate, prolonged second stage with limited descent, significant maternal exhaustion, or a medical reason to shorten pushing. Assistance may involve vacuum or forceps, performed by a trained clinician when criteria are met, including adequate cervical dilation, known fetal position, and appropriate station. If vaginal birth is not considered safe or feasible, cesarean birth may be recommended.

These decisions can feel sudden, especially after many hours of labor. Whenever time allows, the team should explain the reason, benefits, risks, and alternatives. In urgent situations, explanations may be brief while safety steps are taken. Asking for a concise summary, such as "What is the concern right now?" can help maintain a sense of involvement.

The moment of birth and immediate newborn care

As the head is born, the team checks for specific issues, such as whether the umbilical cord is around the neck. A cord around the neck is relatively common and can often be slipped over the head or managed during delivery. After the head, the shoulders usually follow with the next contraction or gentle guidance. Once the baby is fully born, the second stage is complete.

If the baby is vigorous and there are no urgent concerns, immediate skin-to-skin contact is often encouraged. This supports temperature regulation, bonding, early feeding cues, and physiologic transition. The baby's breathing, color, tone, and heart rate are assessed. Apgar scores are commonly assigned at one and five minutes; they are a structured snapshot of newborn adaptation, not a prediction of long-term health.

Delayed cord clamping may be offered in many births when clinically appropriate. This allows additional placental blood transfer to the baby for a short period. However, timing can change if the baby needs urgent resuscitation or if there is significant maternal bleeding. The care team balances newborn transition and maternal safety in real time.

For the birthing person, the immediate moment after birth can bring relief, shaking, tears, laughter, quiet focus, or emotional numbness. All of these responses can be normal. The body has completed a profound physiologic event, and the next stage begins almost immediately: placental separation and delivery.

Placental delivery and early recovery

The third stage of labor is the interval from the baby's birth to delivery of the placenta. The uterus continues contracting, the placenta separates from the uterine wall, and it is delivered through the vagina. This may happen within minutes, though timing varies. Many settings recommend active management of the third stage, which may include a uterotonic medication, controlled cord traction, and uterine massage when indicated to reduce the risk of postpartum hemorrhage.

After the placenta is delivered, the clinician examines it to check that it appears complete. Retained placental tissue can contribute to bleeding or infection, so this assessment is clinically important. The team also checks the uterus for firmness and monitors bleeding. A firm, contracted uterus helps

compress blood vessels where the placenta was attached.

The perineum, vagina, and cervix may be examined for lacerations. If repair is needed, local anesthesia or existing epidural anesthesia may be used depending on the situation. Tears are described by degree, from superficial first-degree tears to more complex injuries involving the anal sphincter. The team should explain findings and repair plans clearly.

Early recovery also includes warmth, fluids if allowed, bladder care, pain assessment, and support with the first feed if desired. Even when delivery is uncomplicated, the first hour requires close observation. Heavy bleeding, dizziness, severe pain, shortness of breath, or feeling faint should be reported immediately. Birth is common, but it is still a major medical and physiologic transition deserving careful attention.

Planning for a flexible, respectful pushing stage

Birth preferences can be helpful when they are framed as priorities rather than rigid scripts. You might note whether you prefer spontaneous pushing if safe, whether you want coaching only when requested, which positions you hope to try, who should be in the room, and how you want information explained during urgent decisions. These preferences can be discussed before labor with an obstetric clinician or midwife.

It is also useful to plan for flexibility. A person who hoped to avoid directed pushing may find coaching reassuring. Someone who wanted an upright position may need side-lying because of epidural density or fetal heart rate changes. A person who planned immediate skin-to-skin may need brief separation if the baby requires help breathing. Flexibility is not a loss of agency; it is part of safe, responsive care.

If you have a history of pelvic floor injury, prior traumatic birth, obstetric anal sphincter injury, cesarean birth, fetal growth concerns, or a medical condition affecting pushing, individualized planning is especially important. Your clinician can discuss risk factors, monitoring, and thresholds for intervention without making assumptions about what you should choose.

Above all, the pushing stage is not a test of strength or worth. It is a

coordinated physiologic and clinical event, supported by skilled care and moment-by-moment decisions. Feeling informed can help you participate actively while still allowing your team to respond to what you and your baby need.