Squatting position for birth explained

What the squatting position means in birth

In childbirth, squatting usually means the birthing person is upright with knees and hips flexed, feet supported, and the pelvis lowered toward the floor or bed. It can be a deep squat, a partial squat, or a supported squat while holding a partner, rope, bed rail, or squat bar. In hospital settings, a common version is using a squat bar attached to the labor bed while the person remains on the mattress between contractions.

Squatting is most often discussed in relation to the second stage of labor, which begins at full cervical dilation and ends with the birth of the baby. During this stage, the fetal head descends through the pelvis, rotates, and stretches the perineal tissues. The position may be used during active pushing, during pauses to encourage descent, or briefly at crowning if it remains comfortable and clinically safe.

It is helpful to separate squatting from the idea of staying in one posture for the entire birth. Many people move between upright positions during labor, such as standing, kneeling, sitting, side-lying, hands-and-knees, and squatting. A squat may be used for a few contractions and then replaced with another position when the legs fatigue or when fetal heart rate assessment requires

adjustment.

Pelvic mechanics and gravity

The rationale for squatting is partly biomechanical. When the hips are flexed and abducted, the pelvic outlet may increase in certain dimensions, especially if the sacrum is free to move backward rather than compressed against a flat surface. This can create more functional space for fetal descent through the lower pelvis. Squatting also places the trunk upright, so contractions and maternal pushing efforts may work with gravity rather than against it.

These mechanics do not mean that squatting will automatically make birth easier. Fetal position, pelvic anatomy, uterine contraction strength, soft tissue resistance, maternal fatigue, pain, anxiety, and prior birth history all influence progress. For example, a fetus in an occiput posterior position may require rotation before descent feels effective, and some people find hands-and-knees or side-lying more comfortable than a squat.

Another important detail is sacral mobility. A deep squat on a bed can sometimes restrict movement if the pelvis is tucked or the person is bracing strongly. A supported squat with the torso leaning forward may allow better alignment and less strain. This is why labor nurses and midwives often help adjust foot placement, knee angle, pelvic tilt, and upper-body support during second stage labor positioning.

What research suggests

The evidence on squatting is encouraging in some respects but not definitive. A review of squatting in the second stage of labor found that available studies do not clearly prove an overall benefit across all outcomes. However, some data suggest that squatting may reduce instrumental delivery, such as forceps or vacuum birth, and may influence cesarean risk in certain study settings. The strength of conclusions is limited by differences in study design, clinical environment, and how squatting was defined.

Earlier cohort research comparing squatting births with semirecumbent births reported shorter second-stage labor, less oxytocin use, and fewer or less severe perineal lacerations among those who squatted. Infant complications were

not significantly different in that study. These findings helped shape the idea that squatting can be a gravity-assisted labor position, though cohort studies can be affected by selection bias; people who can squat may already differ from those who cannot.

A more recent hospital-based randomized controlled trial comparing squatting with supine positioning also reported shorter second-stage labor, less oxytocin use, less episiotomy extension, and higher maternal satisfaction in the squatting group. This supports offering squatting as an option when appropriate. Still, clinical decisions should not be based on position alone. Continuous assessment of fetal heart rate, maternal blood pressure, bleeding, pain control, and labor progress remains central.

Potential benefits for the birthing person

For some people, squatting during childbirth provides a stronger sense of agency. The posture can feel active, grounded, and responsive to contractions. Being upright may also reduce the sensation of working against the bed, particularly for someone who dislikes lying flat. In studies where maternal satisfaction was measured, squatting groups sometimes reported a more positive experience.

Possible clinical benefits include a shorter second stage, reduced need for oxytocin augmentation, and fewer instrumental deliveries in some research. These outcomes may relate to gravity, pelvic outlet mechanics, and more effective alignment between uterine contractions and maternal effort. Some people also find it easier to bear down in a squat because the position resembles a natural defecation posture, which can coordinate pelvic floor relaxation with abdominal pressure.

Perineal outcomes are more nuanced. Some studies report fewer or less severe lacerations, while others do not show a consistent protective effect. The speed of fetal head emergence, tissue elasticity, clinician support, fetal size and position, and whether an episiotomy is used may matter more than posture alone. A slow, controlled birth of the head may be difficult if the person feels unstable or is pushing forcefully in a deep squat, so guidance at crowning can be important.

Limits, cautions, and when to modify

Squatting can be physically demanding. It requires leg strength, balance, ankle mobility, and enough energy to maintain the posture during intense contractions. Fatigue can reduce stability and make pushing less coordinated. Many people do better with supported squatting in labor rather than an unsupported deep squat. Support can come from a squat bar, partner, doula, midwife, nurse, or adjustable bed.

An epidural does not always rule out squatting, but it changes the safety assessment. Dense epidural analgesia may cause leg weakness, reduced proprioception, or impaired balance. In that situation, a full standing squat may be unsafe, while a modified squat on the bed, side-lying, or semi-sitting may be more appropriate. Some hospitals allow squat bars with epidurals only when staff can provide close physical support.

Squatting may also need to be avoided or stopped if fetal heart rate patterns are concerning, if urgent operative birth is needed, if there is significant bleeding, if the birthing person feels faint, or if blood pressure changes require a different posture. People with certain hip, knee, pelvic girdle, neurologic, or musculoskeletal conditions may need alternatives. The safest position is the one that supports both maternal physiology and timely clinical care.

How to prepare before labor

Preparation starts with a conversation, not a rigid plan. During prenatal visits, ask whether the birth setting has squat bars, birth stools, floor mats, wireless fetal monitoring, or staff comfortable with upright positions during labor. If epidural analgesia is likely or planned, ask what position changes after epidural analgesia are usually supported in that unit. Policies vary, and knowing the options ahead of time can reduce stress during labor.

Physical preparation can include practicing brief supported squats, pelvic mobility, and upright rest positions if your clinician says these are appropriate. The goal is not athletic performance; it is familiarity. Holding a deep squat for long periods is rarely necessary. More useful skills include relaxing the pelvic floor while supported, keeping the feet stable, changing

positions smoothly, and recognizing when the legs are too tired.

It can also help to write flexible preferences in a birth plan: for example, wanting freedom of movement during labor, trying a squat bar during pushing if safe, and alternating with side-lying or hands-and-knees if needed. A flexible plan gives the team permission to support your preferences while still responding to labor's clinical realities.

Using squatting during the second stage

During second stage, squatting is usually tried contraction by contraction. Between contractions, the birthing person may rest in sitting, kneeling, or side-lying to conserve energy. When a contraction builds, they may rise into a supported squat, hold the squat bar, lean into a partner, or lower into a partial squat on the bed. This rhythm can make the position more sustainable.

Breathing and pushing style should be individualized. Some people use spontaneous pushing, bearing down only when the body urges them to. Others use coached pushing for specific clinical reasons. In a squat, pushing too forcefully before the tissues have stretched may increase discomfort or reduce control at crowning. The clinician may suggest panting, smaller pushes, or changing position if the head is emerging quickly.

The team should also watch practical details: stable foot placement, non-slip surfaces, clear access for fetal heart rate checks, and enough staff support if legs become weak. If squatting stops helping, that is not a failure. Birth positions are tools, not tests. A change to side-lying, kneeling, sitting, or semirecumbent positioning can be the right clinical move at that moment.