What is the pushing stage and when it begins

Defining the pushing stage

The pushing stage is the second stage of labor: it begins at full cervical dilation and ends with the birth of the baby. In practical terms, this means the cervix has opened enough for the presenting part, usually the baby's head, to pass through the cervix and descend through the birth canal. Clinically, full dilation is often described as approximately 10 cm, although the exact assessment is made by a trained clinician through examination and observation of labor progress.

This stage is different from the first stage of labor, when contractions primarily dilate and efface the cervix. Once the cervix is fully open, the focus shifts toward descent, rotation, and expulsion of the baby. The uterus continues to contract, but the birthing person may also contribute with bearing-down efforts when appropriate. This is why the phrase pushing stage and delivery is commonly used: the stage is not only about pushing, but also about the baby's final movement through the pelvis and out into the world.

It can be helpful to distinguish the pushing stage from the third stage of labor. The second stage ends when the baby is born. The third stage begins after birth and ends with placental delivery. This distinction matters because

the goals, monitoring, and possible interventions differ from one stage to the next.

When the pushing stage begins

The pushing stage begins when there is full cervical dilation. For most labors, this is around 10 cm. Before that point, pushing strongly may be discouraged because the cervix may still be partly in the way. Pushing against an incompletely dilated cervix can be ineffective and may contribute to cervical swelling or maternal fatigue. This is why a clinician may ask someone to breathe through contractions or use positions that reduce pressure until full dilation is confirmed.

Full dilation does not always mean that active pushing should start immediately. The baby's head may still be relatively high in the pelvis, especially with an epidural or in a first birth. In those cases, the care team may recommend a period of passive descent during labor, sometimes called laboring down. During this time, contractions continue to move the baby lower while the birthing person rests, changes position, or waits for a more compelling urge to push, provided maternal and fetal conditions remain reassuring.

Some people feel an unmistakable urge to bear down as soon as they are fully dilated. Others feel pressure but no clear pushing reflex. Both patterns can be normal. The decision about when to begin active pushing in labor is usually individualized, taking into account cervical dilation, fetal station, contraction pattern, fetal heart rate, maternal energy, pain relief, and the overall birth plan.

What pushing feels like

The sensations of the second stage of labor can be powerful. Many people describe intense pressure in the pelvis, vagina, and rectum. The urge to push may feel like an urgent need to pass stool, because the baby's head presses on the rectum and pelvic floor. This feeling is common and can be reassuring once it is understood as a normal sign of descent rather than something embarrassing or wrong.

Contractions during this stage often come with waves of pressure that build, peak, and ease. Some people instinctively curl around the contraction, hold their breath briefly, or make deep sounds while bearing down. Others prefer open-glottis pushing, breathing out slowly while pushing, or changing positions frequently. With an epidural, sensations may be more muted; the person may feel pressure rather than pain, or may need coaching to recognize when a contraction is happening.

Emotionally, the pushing stage can feel empowering, overwhelming, vulnerable, or all of these at once. It is normal to need encouragement, quiet, clear instructions, or reassurance. A supportive team can help translate clinical information into practical guidance: when to rest, when to push, when to change position, and when the baby is making progress even if birth still feels far away.

How pushing is guided

There is more than one way to push. Spontaneous pushing means the birthing person follows their own urge to bear down, often pushing several shorter times during a contraction. Directed pushing usually means a clinician or nurse coaches the person to take a breath, hold it, and push for a set count during contractions. Delayed pushing means waiting after full dilation until the urge to push becomes stronger or the baby descends further, if it is safe to wait.

Research comparing pushing methods has found that delayed pushing can shorten the actual time spent actively pushing by about 19 minutes and may increase spontaneous vaginal birth rates, although it can also lengthen the total second stage by about 56 minutes. This illustrates an important nuance: less time actively pushing does not always mean a shorter second stage overall. It may mean a longer period of descent before active effort begins.

The safest and most comfortable approach is not the same for everyone. Directed pushing may be useful when the urge is absent, when epidural anesthesia reduces sensation, or when more coordinated effort is needed. Spontaneous pushing may feel more physiologic and less exhausting for some people. Delayed pushing may help conserve energy when the baby is still high, but it may not be appropriate if there are concerns about fetal heart rate, maternal bleeding, infection, or other complications. The care team’s role is to balance physiology, comfort,

and safety in real time.

How long the pushing stage may last

The duration of the pushing stage varies widely. In a first pregnancy, the second stage may last from about 30 minutes to three hours. For someone who has previously given birth vaginally, it is often shorter. The NHS notes that for first-time mothers it should typically not exceed 3 hours, while for those who have had a baby before it should take no more than 2 hours. These time frames are general clinical references, not a personal deadline or prediction.

Several factors influence duration. A first birth often takes longer because the pelvic floor and soft tissues are stretching for the first time. Epidural analgesia may reduce the urge to push and can be associated with a longer second stage, though many people with epidurals have uncomplicated vaginal births. Fetal position also matters: a baby facing the mother’s abdomen, sometimes called occiput posterior, may descend and rotate more slowly. Contraction strength, pelvic anatomy, maternal fatigue, hydration, and fetal size can also affect progress.

Clinicians do not judge progress by the clock alone. They also assess fetal station in labor, meaning how low the baby’s presenting part is in relation to the maternal pelvis. They may observe whether the head descends during contractions, whether it remains lower between contractions, and whether the fetal heart rate pattern remains reassuring. If descent is steady and mother and baby are well, continued pushing may be reasonable. If progress stops or concerns arise, the team may discuss options.

Positions, breathing, and conserving energy

Position changes can support descent and comfort during the pushing stage. Upright or forward-leaning positions may use gravity and widen certain pelvic dimensions. Side-lying may reduce fatigue, allow rest between contractions, and sometimes ease pressure on the perineum. Hands-and-knees can be useful for some fetal positions or back pressure. Semi-reclined positions are common in hospital settings, particularly with epidural anesthesia, but they are not the only option.

Breathing strategies should match the person’s body, preferences, and clinical situation. Some people naturally hold their breath for short periods while pushing; others prefer exhaling through the effort. Long, repeated breath-holding may be tiring for some and is not always necessary. The goal is effective downward effort while maintaining oxygenation, focus, and enough recovery between contractions.

Rest matters. The pushing stage is active work, but every contraction is followed by a pause. Using that pause to release tension in the jaw, shoulders, hands, and pelvic floor can help conserve energy. Sipping fluids if allowed, using cool cloths, receiving calm verbal support, and limiting unnecessary noise may all help the birthing person stay present. Even small adjustments can make the stage feel more manageable.

Monitoring and when extra help may be needed

During the second stage of labor, the care team monitors both the birthing person and the baby. This may include checking maternal blood pressure, pulse, temperature, pain, exhaustion, bleeding, bladder fullness, and contraction pattern. Fetal monitoring may be intermittent or continuous depending on risk factors, medications, and local practice. The purpose is not to interfere with birth unnecessarily, but to identify early signs that the plan should change.

Additional assessment may be needed if pushing is prolonged, the baby does not descend, the fetal heart rate becomes concerning, contractions weaken, or the birthing person becomes too exhausted to continue effectively. In some circumstances, clinicians may discuss assisted vaginal birth with vacuum or forceps, or cesarean birth if vaginal birth is not considered safe or feasible. These decisions depend on cervical dilation, fetal station, fetal position, maternal condition, fetal condition, and the expertise available.

Perineal support during birth may also be offered as the baby’s head crowns. The clinician may guide the speed of birth of the head, support the perineal tissues, or suggest small pushes or panting to reduce sudden stretching. Tears can still occur, and some may require repair after birth. The key is that support should be explained, consent-based whenever possible, and responsive to the person’s comfort and clinical needs.

The moment of birth and transition afterward

As the baby’s head reaches the perineum, the tissue stretches and the sensation may become intense, often described as burning, stinging, pressure, or stretching. This moment is called crowning. The care team may encourage controlled, gentle pushing rather than forceful bearing down. Once the head is born, the shoulders and body usually follow with the next contraction or with gentle assistance from the clinician.

The second stage ends at the birth of the baby. If mother and baby are stable, many teams prioritize immediate skin-to-skin contact, drying the baby, assessing breathing and tone, and supporting early bonding. At the same time, clinicians remain attentive to bleeding, uterine tone, cord management, and the beginning of the third stage. The emotional shift can be enormous: relief, joy, shock, trembling, tears, silence, or disbelief are all common responses.

For many people, understanding the pushing stage in advance makes it easier to participate in decisions during labor. Still, birth is dynamic. Preferences about pushing style, positions, or coaching may need to adapt to pain relief, fetal position, fatigue, or medical concerns. A flexible plan, clear communication, and trust in a qualified healthcare team can help protect both safety and dignity during this profound stage of birth.