What pushing feels like during labor

Where pushing fits in labor

Pushing usually belongs to the second stage of labor, the phase after the cervix has reached full dilation and the baby moves down through the pelvis toward birth. Full dilation means the cervix has opened enough for the baby to descend, but it does not always mean a person immediately feels ready to push. There may be a pause, a sense of pressure without direction, or a powerful involuntary bearing-down reflex.

This is why the pushing stage and delivery can feel less like a single event and more like a changing sequence. Early in the second stage, contractions may still feel similar to late first-stage contractions, but the pressure often drops lower into the pelvis. As the baby's head descends, sensation commonly becomes more localized: rectal pressure, pelvic fullness, vaginal pressure, stretching, and eventually crowning sensations.

Some people describe pushing as purposeful and active, almost like their body finally has a task to do. Others experience it as overwhelming, disorienting, or difficult to coordinate. Both reactions are understandable. Pushing uses the uterus, diaphragm, abdominal wall, pelvic floor, and maternal positioning, but the person giving birth may experience it mainly as pressure, pain, intensity,

or an uncontrollable urge.

The urge to push

The classic description is an urge that feels like needing to poo. This happens because the baby's presenting part, usually the head, presses on the rectum, pelvic floor, and nearby nerves. The sensation can be startlingly literal: many people worry they are about to pass stool, even when what they are mainly feeling is the baby moving downward. Care teams are used to this, and it is a normal part of many vaginal births.

The urge may arrive in waves with contractions. Between contractions, the pressure may ease slightly, giving a short break. During a contraction, the body may curl forward, the breath may catch, and bearing down may feel almost automatic. Some people describe it as a reflex stronger than conscious choice, as if the body is pushing from the inside.

Not everyone feels this urge clearly. The urge may not appear immediately after full dilation, particularly if the baby is still relatively high in the pelvis.
Some people feel pressure but not a clear command to push. With epidural analgesia during pushing, the urge can be reduced or absent, depending on the dose, timing, and individual response. In that situation, pushing may be guided by contraction patterns, fetal station, and coaching from the midwife, nurse, or obstetric team.

Pressure, effort, and body mechanics

Pushing is often described as pressure more than sharp pain, especially at first. The pressure may feel deep in the pelvis, rectum, sacrum, pubic bone, hips, or lower abdomen. Some people feel a strong downward heaviness; others feel their pelvis widening or their tailbone being pressed from within. If the baby is in a posterior position or the back of the head presses toward the sacrum, back or rectal pressure may be especially prominent.

The physical effort can be intense. Active pushing in labor may feel similar to the bearing-down effort used for a bowel movement, but much stronger and coordinated with contractions. People may instinctively hold their breath, vocalize, grip supports, squat, curl around the belly, or change position.

Others may use open-glottis pushing, exhaling or making low sounds while bearing down. Which approach is used depends on maternal comfort, fetal status, epidural effects, local practice, and clinical guidance.

The body may also shake, sweat, feel hot, or feel briefly nauseated. These responses can reflect exertion, hormones, pain, fatigue, or the intensity of transition into birth. Emotionally, the same sensations may feel empowering to one person and frightening to another. A medically literate framing is useful here: sensation does not map perfectly onto progress. Strong pressure can occur before birth is imminent, and minimal sensation can still accompany effective descent, particularly with neuraxial analgesia.

How sensations change as the baby descends

As descent continues, pushing sensations usually become more specific. Early pressure may feel broad and internal. Later, it may feel lower, more vaginal, and more focused around the perineum. Some people can feel the baby's head moving down during a contraction and then slipping back slightly between contractions. This back-and-forth movement can be frustrating, but it often reflects gradual stretching of tissues and stepwise descent.

When the head stretches the vaginal opening and perineum, many people feel burning, stinging, or an intense stretching sensation. This is often called the ring of fire, although the intensity varies. For some, it is the most painful part of birth; for others, the pressure is so dominant that the burning feels secondary. Perineal stretching during birth may be accompanied by a feeling that the tissues cannot stretch further, even though they often continue to do so with time, positioning, and support.

Crowning can feel very different from earlier pushing. Instead of a wave that recedes fully between contractions, the stretch may remain more constant. A clinician may ask the birthing person to pant, breathe gently, slow the push, or pause briefly to support controlled birth of the head. These instructions are not about willpower; they are often intended to help tissues stretch gradually and allow the team to monitor mother and baby closely.

Pushing with an epidural

Epidural analgesia can substantially change what pushing feels like. Some people still feel rectal pressure, pelvic fullness, or the beginning of each contraction, while others feel little or no urge to push. A person may know it is time to push because the monitor shows contractions, the care team palpates the abdomen, or a clinician confirms descent during an examination.

With an epidural, pushing may feel more strategic than instinctive. The care team may suggest waiting for stronger descent before active pushing, sometimes called delayed pushing or laboring down, depending on the clinical situation. This can allow contractions to move the baby lower before the person begins directed effort. In other circumstances, coached pushing during contractions may begin once full dilation is confirmed and the team judges that active effort is appropriate.

The absence of pain does not mean the person is disconnected from birth, and the presence of pressure does not mean the epidural is failing. Epidural effects exist on a spectrum. Some people feel enough sensation to push effectively with minimal coaching; others need more guidance about when and where to direct effort. If pain becomes severe, one-sided, or suddenly changes, it is reasonable to tell the anesthetic or obstetric team so they can assess what is happening rather than assuming it is simply normal labor pain.

When pushing feels relieving, painful, or frightening

Many people are surprised that pushing can feel relieving. After the intensity of transition, bearing down may make contractions feel more productive or tolerable because the body is no longer resisting the urge. Some describe a focused, athletic quality: contraction, push, rest, repeat. The short rest between contractions can become psychologically important, even if the overall experience is exhausting.

For others, pushing hurts more than contractions. Rectal pressure can feel alarming, the stretching can be severe, and fatigue can make each contraction feel harder to meet. A person who has been awake for many hours may experience shaking, crying, irritability, or a feeling of being unable to continue. These reactions do not imply weakness. They are common human responses to pain, prolonged effort, and the vulnerability of birth.

Pushing can also feel emotionally exposed. The sensations involve parts of the body associated with elimination, sexuality, and privacy. Fear of tearing, fear of stooling, past trauma, or uncertainty about what the team is doing can amplify distress. Trauma-informed support matters: clear explanations, consent before examinations when possible, privacy, respectful language, and choices about position can change how manageable the same physical sensations feel.

What to communicate to your care team

Because pushing sensations vary, communication helps the care team distinguish expected intensity from something that needs assessment. Tell your midwife, nurse, or obstetrician if you feel a sudden change in pain, severe pain between contractions, chest pain, faintness, heavy bleeding, a feeling that something is wrong, or if you cannot feel contractions well enough to coordinate pushing. Also speak up if instructions are confusing, if a position feels impossible, or if you need a pause to understand what is happening.

It can be useful to use concrete language: pressure in the rectum, burning at the vaginal opening, one-sided pain, back pressure, no urge to push, or constant pain between contractions. These details are more clinically helpful than trying to label the sensation as normal or abnormal yourself. The team can assess cervical dilation, fetal station in labor, fetal heart rate, contraction pattern, maternal vital signs, bladder fullness, analgesia level, and whether position changes might help.

Above all, pushing is not a performance test. It is a physiologic process happening in a clinical and emotional context. The safest interpretation of any sensation comes from combining what the birthing person feels with professional assessment. If something feels unexpected or frightening, asking for explanation is appropriate. Support, monitoring, and shared decision-making can make the pushing stage feel less mysterious, even when it remains intense.