SPEECH ACTS OF A PROFESSIONAL THERAPIST IN SPEECH SPEECH DELAY THERAPY: A PRAGMATICS STUDY

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Abstract. This study examines the use of speech acts by a professional therapist during speech delay therapy for a preschool child. Grounded in pragmatics and Searle's classification of illocutionary acts, this research employed a qualitative case study design. Data were collected through direct observation of therapy sessions, semi-structured interviews with the therapist and parents, and audio documentation at Pusat Tumbuh Kembang Anak AL-Insan Cirebon. Analysis of 520 therapist utterances identified four illocutionary act types: directives (363, 69.8%), assertives (125, 24.0%), expressives (29, 5.6%), and commissives (3, 0.6%); declaratives were absent. Directives, which were primarily commands (223) and questions (134) structured the session and elicited verbal responses. Assertives functioned as language modeling and immediate correction tools. Expressives built emotional rapport and reinforced desired behavior through praise and empathy. Commissives managed behavior via conditional promises and deliberate refusals. Together, these act types form an integrated therapeutic communication architecture that simultaneously instructs, models, supports, and regulates. This study contributes pragmatic insight to clinical speech therapy and offers practical guidance for therapists and parents.

Keywords: illocutionary acts, pragmatics, speech acts, speech delay, speech therapy

Abstrak. *Penelitian ini mengkaji penggunaan tindak tutur oleh seorang terapis profesional dalam terapi speech delay pada anak usia prasekolah. Berlandaskan kajian pragmatik dan klasifikasi tindak ilokusi Searle, penelitian ini menggunakan desain studi kasus kualitatif. Data diperoleh melalui observasi langsung sesi terapi, wawancara semi-terstruktur dengan terapis dan orang tua, serta dokumentasi audio di Pusat Tumbuh Kembang Anak AL-Insan Cirebon. Analisis terhadap 520 tuturan terapis mengidentifikasi empat jenis tindak ilokusi: direktif (363, 69,8%), asertif (125, 24,0%), ekspresif (29, 5,6%), dan komisif (3, 0,6%); sedangkan deklaratif tidak ditemukan. Direktif terutama perintah (223) dan pertanyaan (134) menstruktur sesi dan memancing respons verbal anak. Asertif berfungsi sebagai pemodelan bahasa dan koreksi langsung. Ekspresif membangun kedekatan emosional dan memperkuat perilaku melalui pujian dan empati. Komisif mengatur perilaku melalui janji bersyarat dan penolakan terencana. Keempat jenis tindak tutur tersebut membentuk arsitektur komunikasi terapeutik terpadu. Penelitian ini berkontribusi pada kajian pragmatik klinis dan memberikan panduan praktis bagi terapis dan orang tua.*

Kata kunci*: ilokusi, pragmatik, speech delay, terapi wicara, tindak tutur*

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INTRODUCTION

Humans are inherently social creatures who fundamentally depend on communication to survive and thrive. Among the many ways humans connect, speaking stands out as a

foundational milestone in child development, enabling children to convey needs, intentions, and feelings. Language acquisition unfolds through continuous interaction between the child and their environment during a critical window from approximately one month up to two and a half years of age. However, when a child surpasses the age of 2.5 years without demonstrating effective language processing abilities whiz is characterized by difficulties in understanding or using language appropriately, this situation may signify the presence of speech delay, a condition that warrants close attention and possible intervention (Agustina et al., 2022). Speech delay can manifest in various ways, including limited vocabulary, unclear articulation, and difficulty forming sentences, all of which can severely impact a child's ability to interact socially and academically. Globally, speech delay is recognized as a common developmental concern. Epidemiological data suggest that approximately 5% to 10% of children under the age of five are affected by this condition, with the World Health Organization (WHO) reporting over 200 million toddlers worldwide experiencing suboptimal developmental progress that includes significant delays in speech and language acquisition (WHO, 2021). Recent research has identified prevalence rates fluctuating from as low as 2.3% to as high as 19%, reflecting significant geographic and methodological variability (Moges et al., 2024). In Indonesia specifically, data from the Indonesian Pediatric Society (IDAI) in 2023 estimates the prevalence of speech delay among preschool-aged children at 5% to 8%, indicating a concerning upward trend that necessitates urgent attention from healthcare providers and policymakers alike (Hutrika et al., 2024).

The clinical presentation of speech delay is highly heterogeneous. Many children experience difficulty sustaining two-way communication, which is a critical aspect of pragmatic language use and social interaction. Notably, some children demonstrate echolalia, a behavior characterized by the repetitive utterance of phrases spoken by others, which may reflect their efforts to process, learn, or compensate for their communicative limitations. This heterogeneity in clinical presentation reinforces the importance of personalized therapeutic strategies and underscores the need to address speech delay as a multifactorial disorder that impacts multiple domains of communicative competence. The causes of speech delay are varied and multifactorial, encompassing a broad spectrum of biological, familial, and environmental influences. On the biological side, conditions such as birth asphyxia, which may lead to oxygen deprivation and subsequent neurological impacts, and congenital oropharyngeal abnormalities are significant contributors to delayed speech development. Familial factors also play a crucial role, where parenting styles characterized by limited verbal interaction or inconsistent language exposure may hamper the linguistic environment young children need to flourish.

In many developing countries including Indonesia, similar etiological patterns emerge, underscoring the importance of educational interventions for caregivers to optimize child-rearing practices that support language development. However, Indonesia faces a significant data gap in both accurate reporting of speech delay cases and equitable access to specialized therapy services, primarily due to economic disparities among its population. Many families struggle to afford or reach professional speech therapy, which hampers early diagnosis and timely intervention that could greatly improve language outcomes. Consequently, a pragmatics-based approach to understanding and addressing speech delay is particularly relevant in this context. The pragmatic approach situates speech acts as the central analytical and therapeutic tool, recognizing that communication disorders are best addressed by understanding the functional use of language within social interactions. This method is particularly apt in Indonesia's distinctive multilingual and culturally rich environment, which differs substantially from prior studies conducted predominantly in Western contexts.

Furthermore, growing up in a multilingual household can introduce additional complexity to language acquisition, potentially causing temporary delays as children differentiate between multiple language systems. Environmental aspects are equally important, as insufficient stimulation through interaction, exposure to trauma, and excessive screen time are found to negatively affect a child's ability to develop speech and communication skills effectively (Sunderajan & Kanhere, 2019). In light of these complex causative factors, speech therapists employ theoretical frameworks such as John Searle's speech act theory to dissect and better understand the communicative behaviors and therapeutic challenges encountered in children with speech delays. This theory facilitates an analysis of how language functions pragmatically in real-life contexts, guiding therapists in crafting goal-directed and contextually appropriate interventions (Alston & Searle, 1970; Ibrahim & Winarsih, 2013). Therapists in clinical settings integrate this pragmatic perspective by deploying communication exercises involving requests and statements that mirror authentic social interactions, thereby helping children not only articulate speech more clearly but also use language purposefully. Creating a warm and receptive therapeutic environment is essential, as it fosters comfort and motivation in children, enhancing their willingness to engage actively (Leech, 1983; Owens, 2011). Intervention strategies further emphasize role-playing techniques and active collaboration with parents, who are coached to provide continuous language stimulation at home, ensuring therapeutic gains are reinforced in daily life (Jafar & Ansar, 2024).

Despite the growing body of research, notable gaps in understanding which specific therapeutic techniques are most effective persist. (Rahim et al., 2021) highlight how teachers in preschool settings effectively employ environmental therapies alongside affection-based methods to enhance speech development. (Muthi et al., 2024) advocate for a holistic therapeutic model incorporating creative learning approaches such as storytelling and singing. (Nursarofah et al., 2022) underscore the significance of repeated correct language use and vigilant observation of the child's verbal output. A case-control study by (Moges et al., 2024) further identified five major determinants of speech and language delay: birth asphyxia (4.58× higher risk), bottle-feeding (4.54×), mother-child separation (2.6×), multilingual family environment (2.31×), and screen time exceeding two hours daily (3.06×). Complementing these findings, a systematic literature review by (Badawieh & Al-Shamsi B A Ms, 2023) revealed that boys are generally at higher risk for language developmental delays than girls, and that low maternal education level constitutes a significant vulnerability factor. While these studies illuminate the prevalence and general management of speech delay, none have conducted a systematic pragmatic analysis of therapist speech at the utterance level, specifically how different types of illocutionary acts function as therapeutic tools within an actual session.

The present study focuses on a specific therapy session at the AL-Insan Cirebon Child Development Center, involving a research subject referred to as Child A, a four-year-old girl diagnosed with speech delay. The initial signs of developmental delay in Child A were identified by her parents as early as eight months of age, primarily through her lack of response when called by name. Until the age of four, her verbal abilities remained limited to basic babbling such as "mama" or "papa", which became increasingly evident when she entered preschool. Although Child A demonstrated a clear understanding of semantic content and could follow the utterances of others, she faced significant challenges in expressive language production. This difficulty compelled her to rely extensively on nonverbal communication and physical gestures to convey her needs, such as mimicking the act of drinking or patting her stomach to indicate hunger. While Child A could process conversations involving tangible objects through pointing, she often experienced confusion when dealing with abstract concepts

Beyond her communicative challenges, Child A exhibited a lack of consistent eye contact and a tendency to be easily distracted during vocabulary exercises. Interestingly, she displayed a unique behavioral trait of occasionally pretending to be unable to speak or write, yet demonstrated remarkable competence and speed in writing when stimulated by a sense of competition with her peers. Child A also possesses notable artistic talents in drawing and coloring. Upon recognizing these symptoms, her parents promptly sought professional intervention. After initially seeking treatment at a Child Development Clinic in Cirebon, which was deemed insufficient due to infrequent bi-weekly sessions, they transferred Child A's care to the current clinic following a peer's recommendation. After six months of consistent therapy, Child A has shown significant progress, transitioning from simple babbling to the ability to construct meaningful words. Her parents envision a future where she may excel as a writer, prioritizing speech therapy not only as a remedial tool but as a foundational step to clarify her speech and enhance her word-processing abilities.

Against this background, the present study was conducted to systematically analyze the pragmatic strategies employed by a professional speech therapist at the illocutionary act level. This study addresses two research questions: (1) What types and functions of illocutionary acts does a professional therapist use during speech delay therapy sessions? and (2) How does a professional therapist employ communication strategies during speech delay therapy sessions? By answering these questions, the study aims to provide both a theoretical contribution to pragmatics research in clinical settings and practical guidance for therapists and parents supporting children with speech delay.

METHOD

This study employed a qualitative case study design (Creswell, 2018). The case study approach was chosen for its high suitability for the central objective of this research: to gain a deep and holistic understanding of the phenomenon of therapeutic interaction in a real context, namely a specific speech therapy session. A critical advantage of the case study method is that it allowed the analysis to connect linguistic data with the therapeutic situation, so that each utterance could be interpreted in relation to the child's specific condition, the therapist's intervention goals, and the ongoing relational dynamics between them. This interpretive depth is not achievable through approaches such as conversation analysis, which tends to focus on conversational microstructure without fully accounting for the broader therapeutic background, or ethnography, which requires long-term observation across multiple social situations rather than intensive analysis of a single structured event. In this study, the case study framework enabled the integration of pragmatic discourse analysis with the clinical context, yielding richer and more therapeutically meaningful interpretations.

Data were collected at Pusat Tumbuh Kembang Anak AL-Insan Cirebon between January 19 and March 4, 2025. Participants included Child A (a four-year-old girl diagnosed with speech delay), the professional therapist (T), and Child A's parents (W and U). Data consisted of 520 therapist utterances extracted from audio-recorded therapy sessions and supplementary semi-structured interviews. Three data collection techniques were employed in accordance with Creswell (2018): (1) direct observation of verbal and nonverbal therapist-child interactions; (2) in-depth interviews with the therapist and parents to elicit contextual and explanatory information; and (3) documentation through audio recording and verbatim transcription. All recordings were double-checked by replaying audio to ensure completeness and accuracy. Institutional permission was obtained from AL-Insan Cirebon, and written informed consent was secured from Child A's parents. All identifying information was anonymized using initials and codes to protect participant privacy.

Data analysis followed the (Matthew B. Miles, A. Michael Huberman, 2013) framework, comprising four stages: (1) data reduction which is sauelection and simplification of raw data, eliminating irrelevant utterances and focusing on therapist speech; (2) data categorization, classification of utterances by illocutionary type and sub-function according to Searle's (1970) taxonomy; (3) data presentation, descriptive narrative, frequency tables, and function matrices; and (4) conclusion drawing and verification, formulation of conclusions verified through data triangulation across observation, interview, and documentation sources.

RESULTS AND DISCUSSION

Analysis of 520 therapist utterances identified four of Searle's five illocutionary act categories actively deployed. Declaratives were entirely absent, consistent with the therapist's lack of the institutional authority required to bring about new realities through utterance alone. The overall distribution is presented in Table 1.

Table 1. The Types of Illocutionary Acts

No	Types of Illocutionary	Frequency	%
1	Assertive	125	24.0
2	Directive	363	69.9
3	Expressive	29	5.6
4	Commissive	2	0.6
	Total	520	100

A. Types of Illocutionary Acts and Functions Use by Therapist During Therapy Session

1. Assertive Acts

Assertive speech acts constituted 24.0% of all utterances and served two principal functions: language modeling through statements and contextual reporting. Assertives served as the therapist's primary language modeling tool, aligning with (Nursarofah et al., 2022) emphasis on using correct and precise language repeatedly as a core strategy in speech delay intervention.

Table 2. The Functions of Assertive Acts

No	Function	Frequency	%
1	Statements	122	97.6
2	Reporting	3	2.4
	Total	125	100

a. Statements

Statement functions served as immediate lexical and conceptual corrections, providing the child with accurate linguistic forms to replace incorrect ones. These assertive embody the word-to-world direction of fit: the therapist's utterance is intended to reflect objective reality, giving the child a correct linguistic template.

Data 1

Childern A: "Engga mau" (I don't want)
*Therapist: "**Kan lagi belajar**"* (You are studying)

Rather than issuing a command, the therapist here asserts a contextual fact to remind the child of the ongoing activity. This utterance serves as both a rationalization and a behavioral anchor, helping the child understand the purpose and expected behavior of the current moment.

Assertive used in this way build the child's understanding of cause-and-effect reasoning, extending the therapeutic function beyond mere language modeling.

Data 2

Child A: "Ibu" (Mother)
*Therapist: "**Bukan ibu, kakak**"* (Not mother, sister)

This assertion directly corrects Child A's misidentification by committing the therapist to the truth of the proposition that the person addressed is 'sister' (kakak), not 'mother' (ibu). The therapist's belief in the factual accuracy of her statement (sincerity condition) underlies the assertion. This immediate correction technique mirrors what (Nursarofah et al., 2022) identify as correcting wrong sentences as a key intervention strategy.

Data 3

Child A: [Berusaha memasang puzzle huruf W di kolom W] ([Trying to put the letter W puzzle in the W column])
Therapist: "Sama, ini tinggal dibalik aja" [Mengarahkan memasang di kolom huruf M] (Same, just turn it over (Pointing to the letter M column])
Child A: "Hah?" (Hah?)
Therapist: "Coba lihat nih, sama kan" (Check it out, it's the same right)
Child A: "Nda, ubid tata yu, wah tumpah" (Nda, ubid tata yu, wah spill)
*Therapist: "**Bukan tumpah, jatuh**"* (Not spill, fall)

This lexical correction is a clear example of assertive language modeling. The therapist asserts that the event was 'falling' (*jatuh*), not 'spilling' (*tumpah*), binding herself to the truth of this more accurate description. From a pragmatic standpoint, such precise corrections develop the child's ability to accurately label events in the environment, what (Skinner, 1948) refers to as accurate 'tacting' behavior.

b. Reporting

Reporting utterances conveyed factual observations about the child's behavioral patterns to a third-party observer (the researcher), providing contextual information that frames the child's communicative behavior within a broader developmental narrative.

Data 1

Child A: "Cucu" (Cucu)
Therapist: "oke lagi, ti su" (Oke again, Ti ssue)
Child A: "Titu" (Titu)
Therapist: "halah lagi, ti su" (halah again, ti, ssue)
Child A: "Oo" (Oo)
*Therapist: "Bukan, Kakak ayunya lagi mau. **Dia sering bercanda**"* (No, it's not. Kaka Ayu is studying. She often jokes)

These reporting utterances provide the researcher with behavioral context that explains the child's inconsistent focus during the session. By distinguishing between Child A's characteristic playful resistance and her capacity for calm engagement under certain conditions, the therapist communicates a nuanced professional understanding of the child's behavioral profile. This type of reporting supports (Sardi et al., 2022) finding that child behavior in therapy is influenced by both internal temperament and contextual factors.

2. Directive Acts

Table 3. The Functions of Directive Acts

No	Functions	Frequency	%
1	Commands	223	61.4
2	Questions	134	36.9
3	Suggestion	2	0.6
4	Scold	2	0.6
	Total	363	100

a. Commands

Commands represent the most frequent single function across all utterance categories. They serve to structure therapy sessions, direct the child's attention, initiate task completion, and elicit articulation practice. The following examples illustrate typical command functions in the session:

Data 1

*Therapist: "**Baca doa dulu yu**"* (Let's read a prayer first)
Child A: "Humm (menolak)" (Hmm [reject])

In this exchange, when Child A resisted with a refusal sound, the therapist deployed an emphatic command to enforce a session boundary. This utterance exemplifies the world-to-word direction of fit, the therapist attempts to make the child's behavior (the world) conform to her words. Within (Skinner, 1948) Verbal Behavior framework, this directive functions as a verbal mind designed to elicit a specific behavioral response. The command also serves to establish a consistent session routine, which is essential for children with speech delay who benefit from predictable structure.

Data 2

Child A: "Enyan, ncu icu" (Enyan, ncu icu)
*Therapist: "**Tiisu, sini lihat ti su**"* (Tissue, here see ti ssue)
Child A: "Cucu" (Cucu)
Therapist: "Oke lagi, ti su" (Okay again, ti ssue)
Child A: "Cucu" (Cucu)

This sequence demonstrates how commands function as repeated articulation prompts. The therapist's persistence in issuing the command "ti su" despite the child's repeated mispronunciation aligns with (Nursarofah et al., 2022) finding that using correct language repeatedly and observing every utterance the child makes are key strategies in handling speech delay. The directive creates a structured opportunity for phonological practice, which (Paul et al., 2017) identify as foundational to language development intervention.

b. Questions

Questions were deployed not merely to seek information but as flexible therapeutic tools to stimulate verbal responses, train decision-making, and guide cognitive processing. Their high frequency (36.9% of all directives) reflects the therapist's strategy of eliciting active participation from the child.

Data 1

Child A: "Popol" (Popol)
Therapist: "Spongebob?" (Spongebob?)
Child A: "Heeh, di umah" (Heeh, at home)
Therapist: "Di rumah?" (At home?)
Child A: "Heeh" (Heeh)
*Therapist: "**Rumahnya emang dimana?**"* (Where is yout home?)
*Child A: "Di ninini" (*In *ninini)*

This exchange demonstrates a referential question used to build on the child's spontaneous topic, extending the conversational turn and encouraging more detailed verbal production. By picking up on the child's interest in a familiar cartoon character, the therapist creates a motivating context for language practice. This aligns with (Muthi et al., 2024) holistic therapeutic model, which advocates for using the child's own interests to engage and stimulate communication.

Data 2

Child A: "Duta" (Open)
Therapist: "Yang mana?" (Which one?)
Child A: "Itu" (That one)
*Therapist: "**Jadi mau coklat yang itu apa yang ini?**"* (So do you want that chocolate or this one?)
Child A: "Nini da" (Nini da)

Choice-based questions such as this effectively direct the child to make decisions and respond verbally with specific language. By offering two alternatives, the therapist reduces the cognitive and linguistic demand on the child while still requiring an active verbal choice, a strategy consistent with (Paul et al., 2017) principle of scaffolded language intervention.

c. Suggestions

Suggestions were deployed as collaborative alternatives when direct commands failed, functioning as a behavioral negotiation strategy to maintain session flow.

Data 1

Therapist: "Engga belajar ga cantik" (You don't learn it's not pretty)
Child A: "Canci" (Pretty)
Therapist: "Engga" (No)
Child A: "Canci" (Pretty)
Therapist: "Kalo ga nurut ga cantik, kakaknya marah, mau?" (If you don't obey, you're not pretty, sister gets angry, do you want to?)
Child A: "..."
*Therapist: "**Yaudah gausah pake yang ini, Kita belajar pake ini aja**"* (Well, don't use this one, let's just learn to use this one)

The shift from command to suggestion reflects the therapist's adaptive communication strategy. When the direct command and mild threat failed to elicit compliance, the therapist offered a face-saving alternative that redirected the session without imposing rigidly. This adaptive approach reflects the importance of flexibility in therapeutic communication that (Yuniari & Juliari, 2020) highlight.

d. Scolds

Scolding appeared only twice, reflecting the therapist's awareness that excessive negative directives would create a psychologically unsafe environment and inhibit the child's willingness to communicate.

Data 1

*Therapist: "Iya minta tolong dulu, nanti kakak ica kasih" (*Yes, ask for help first, later sister ica will give you)
Child A: "mamau" (I don't want)
Therapist: "Alhamdulillah Hirobbil Alamin" (Alhamdulillah Hirobbil Alamin)
Child A: "Mamau" (I don't want)
*Therapist: "**Itu kakaknya sempit**"* (The sister feels cramped*)*

Rather than issuing an explicit reprimand, the therapist employed an indirect scolding by describing the discomfort her behavior caused to others. This approach enforces a behavioral boundary while preserving the child's dignity and the positive therapeutic relationship. The minimal use of scolding is consistent with the positive reinforcement emphasis advocated by (Paul et al., 2017).

3. Expressive Acts

Although comprising only 5.6% of utterances, expressive speech acts performed a role disproportionate to their frequency. They created the psychological safety and emotional rapport that served as a prerequisite for any therapeutic progress, functioning as the 'social glue' that transformed therapy sessions from a series of tasks into warm, supportive human interactions.

Table 4. The Functions of Expressive Acts

No	Types of Error	Amount	%
1	Thanking	11	37.9
2	Expressing Surprises	6	20.7
3	Congratulations	5	17.2
4	Complaints	4	13.8
5	Apologize	2	6.9
6	Welcome	1	3.4
	Total	29	100

a. Thanking

Thanking was the most dominant expressive function, frequently manifested through culturally embedded religious expressions that serve simultaneously as gratitude, goodwill, and spiritual framing of therapeutic work.

Data 1

Therapist: "baca doa dulu yuk" (let's read the prayer first)
Child A: "humm (menolak)" (humm [refuse])
Therapist: "Baca doa dulu, harus baca doa, ***Bismillahirrahmanirrahim****" (*Read the prayer first, must read the prayer*, Bismillahirrahmanirrahim)*

These religious expressions function as expressive acts of gratitude directed not at the child but at a higher entity, expressing the therapist's psychological state of thankfulness, hope, and positive aspiration for the child's progress. The direction of fit for expressives is null, the therapist does not attempt to change the world through these utterances but rather manifests her inner attitudes and values. Importantly, these expressions also model for the child culturally appropriate ways of expressing gratitude and hope, contributing to the child's broader social-communicative development within an Indonesian Islamic cultural context.

b. Expressing Surprise

Expressions of surprise emerged as spontaneous, emotionally charged reactions to the child's unexpected success, making them functionally distinct from deliberate, planned praise. Because they arise in the moment rather than being pre-formulated, these expressive often carry greater emotional authenticity and therefore stronger reinforcing power for the child.

Data 1

Child A: "Ehehehehe, dow, edow, hkmm" (Ehehehehe, dow, edow, hkmm)
Therapist: "Hkmm, en" (Hkmm, en)
Child A: "En" (En)
Therapist: "Na nas" (Pine apple)
Child A: "Nanas" (Pineapple)
Therapist: "***Eeh sudah bisa***" (Ehh already can)

The exclamation "Eeh sudah bisa!" expresses genuine, spontaneous surprise at the child's achievement of correctly pronouncing a target word. From a reinforcement theory perspective (Paul et al., 2017; Skinner, 1948), this expressive reaction serves as immediate positive feedback that increases the probability of the child repeating the desired behavior. The spontaneity of the surprise expression makes it more emotionally authentic and thus more reinforcing than a deliberate compliment. This finding aligns with (Rahim et al., 2021) emphasis on affection-based methods in speech development.

c. Congratulations

Unlike expressions of surprise, congratulatory and praising utterances were more deliberate and evaluative, explicitly labeling the child's action or ability in positive terms. This function directly operationalizes the positive reinforcement principle central to both (Skinner, 1948) Verbal Behavior framework and (Paul et al., 2017) language intervention approach.

Data 1

Child A: "Ahh idak" (Ahh no)
Therapist: "Terbaik, lagi" (Quess, again)
Child A: "Ini?" (This?)
Therapist: "Bukan" (Not)
Child A: "Ini?" (This?)
Therapist: "Iyaa, ***Pinter ya,*** *lagi"* (yes, clever, again)

Praise such as "pinter ya" (how clever) directly labels the child's action as intelligent and commendable. As (Paul et al., 2017) emphasize, providing positive reinforcement when a child makes communication efforts is crucial for facilitating language development. The therapist's praise here serves as a positive consequence that reinforces the child's correct response, increasing the likelihood of repetition. The immediate follow-up directive ("lagi" / "again") efficiently links the positive reinforcement to the next practice opportunity, demonstrating the integrated deployment of expressive and directive acts.

d. Complaints

Complaints occurred when the child repeatedly failed to comply with instructions or lost focus during a task. Rather than expressing overt anger, the therapist channeled frustration through mild, culturally embedded expressions, allowing negative feelings to be voiced without damaging the therapeutic relationship.

Data 1

Therapist: "La lat, mana suaranya?" (La lat, where's the sound?)
Child A: "Ihihihihi" (Ihihihihi)
Therapist: "La lat" (Fly)
Child A: "Ihihihihi" (Ihihihihih)
Therapist: "Nih, ka" (Here, ka)
Child A: "Emm" (Emm)
*Therapist: "**Astaghfirullahaladzim**" (Astaghfirullahaladzim)*

The utterance "Astaghfirullahaladzim" functions as a culturally embedded complaint expression, an outburst of mild frustration at the child's continued non-compliance with articulation instructions. Crucially, this complaint is directed at the situation rather than at the child, modeling for the child how to express frustration appropriately and safely. This expressive management of negative emotions aligns with the therapeutic principle that children benefit from observing healthy emotional expression in their interlocutors.

e. Apologize

Apologies were rare but notable, appearing when the therapist perceived that her own action or response may have caused mild disappointment or discomfort to the child. These utterances functioned less as corrections of a real fault and more as demonstrations of social accountability and emotional attunement.

Data 1

Childern A: "Yah datoh" (Yah datoh)
Therapist: "Mana? Coba kakak ayu yang ambil" (Where? You should try to get it)
Child A: "Cuca" (Cuca)
Therapist: "Bisa, ini dimundurin dulu" (Can, this is postponed first)
Child A: "Mudu, je" (Mudu, je)
Therapist: "Je" (Je)
Child A: "Ce, koma, yah" (Ce, comma, yah)

Therapist: "Yah, ***maaf****, terima kasih"* (Well, sorry, thank you)

The therapist's apology, even for a minor or ambiguous incident, models humility and social accountability. These are high-level pragmatic and social skills that are particularly important for a child developing language and social awareness. The therapist acknowledges the child's emotional response and responds with appropriate social repair, demonstrating real-world pragmatic competence in action.

f. Welcomes

Occurring only once in the entire dataset, this expressive function marked a moment of polite social acknowledgment rather than a therapeutic intervention per se, yet it still contributed to modeling everyday pragmatic norms for the child.

Data 1

Therapist: "Kita tolong helicopter atau pesawat? (Can we please have a helicopter or a plane?)
Child A: "Toteng" (Helicopter)
Therapist: "Helicopter, satu, dua, tiga tarikk" (Helicopter, one, two, three pull)
Child A: "Daikk, yee" (Daikk, yee)
Therapist: "Lagi" (Again)
Child A: "Awat" (Watch out)
*Therapist: "****Permisi****"* (Excuse me)

The single use of "Permisi" (Excuse me) functioned as a polite gesture to signal to the child that the therapist was about to enter her personal space or activity. This expression models courtesy and turn-taking behavior, both of which are fundamental pragmatic skills children with speech delay need to develop for effective social communication.

4. Commissive Acts

Despite their very low frequency, commissive speech acts played a strategically decisive role in behavioral management. Their rarity indicates they were reserved for critical junctures where other strategies proved insufficient. All three commissive employed explicit contingency structures, a behavior required from the child linked to a therapist's future action, functioning as precise behavioral management tools.

Table 5. The Functions of Commissive Acts

No	Types of Error	Amount	%
1	Promising	2	66.7
2	Refusals	1	33.3
	Total	3	100

a. Promising

Both instances of promising occurred at moments of behavioral resistance, when Child A refused to proceed with a task. Rather than resorting to a firmer command, the therapist offered a conditional promise that linked compliance to a desirable subsequent activity, transforming a potential conflict into a cooperative exchange.

Data 1

Therapist: "Hari" (Day)
Child A: "Tayi" (Poop)
Therapist: "Bukan tai, hari nih" (Not a poop, day, here)
Child A: "Be" (Be)
Therapist: "Udah?" (Already)
Child A: "Beyom beyom" (not yet, not yet)
Therapist: "Oh belum, ***dihabiskan dulu baru abis itu kita belajar****"* (Oh not yet, spend it first and then we'll learn)

This conditional promise establishes a clear behavioral contingency: the therapist commits to a desirable future action ('we will learn together') as a positive consequence if the child first completes a prerequisite ('finish it first'). This is a commissive in the world-to-word direction, the therapist commits her own future actions to align with her words. Within (Skinner, 1948) framework, this functions as a form of contingency management that motivates compliance by making the reward predictable and contingent on behavior. This strategy is consistent with what (Yuniari & Juliari, 2020) recommend as a behavior regulation strategy for parents to adopt at home

Data 2

Therapist: "Malu ga?" (Are you ashamed)
Child A: "Mamau" (I don't want)
Therapist: "Ayo duduk" (Let's sit down)
Child A: "Mamau" (I don't want)
Therapist: "Ayo duduk" (Let's sit down)
Child A: "Diyi, mayal" (Diyi, mayal)
*Therapist: "****Iya minta tolong dulu, nanti kakak ica kasih****"* (Yes, ask for help first, later sister ica will give it)

This promise serves as an incentive to break a behavioral deadlock. The therapist commits to giving the child what she wants, but only after the child performs the socially appropriate act of asking for help. This strategy simultaneously manages behavior and models pragmatic skills, specifically, how to make polite requests, reinforcing the dual therapeutic function of commissive.

b. Refusals

The single instance of refusal was a deliberate, strategic choice rather than genuine unwillingness to help. It arose when Child A sought assistance for a task she was capable of completing independently, prompting the therapist to withhold aid in order to encourage self-reliance.

Data 1

Therapist: "Harimau" (Tiger)
Child A: "Gaboye" (No way)
Therapist: "Hah? Ha pe" (Huh? Hand phone)
Child A: "Gaboye" (No way)
Therapist: "Boleh, ku cing" (Yes, cat)
Child A: "Engga tata ayu" (No, sister ayu)
Therapist: "Kenapa? ***Aku ga akan bantu kamu,*** *yuk pasangnya diselesaiin dulu"* (Why, I won't help you, let's finish the fitting first)

This refusal is not a sign of indifference but a deliberate commissive commitment to non-action, designed to promote the child's independence and problem-solving capacity. The therapist explicitly commits to withholding help ('I will not help you') and immediately redirects the child to independent task completion ('let's finish putting it together first'). This strategy reflects a sophisticated understanding that appropriate therapeutic support sometimes means deliberately stepping back to encourage autonomy, a principle that (Yuniari & Juliari, 2020) identify as central to empowering children with speech delay.

B. The Communicative Strategies of Speech Acts Use by A Professional Therapist

The therapist's speech does not constitute a series of arbitrary utterances but rather a deliberate and adaptive architecture of communicative strategy. The differentiated deployment of directive, assertive, expressive, and commissive acts reflects a holistic intervention design in which each illocutionary type functions as a distinct therapeutic instrument, situated at the intersection of pragmatic theory and verbal behavior reinforcement theory.

1. Implication Use of Directive Speech Acts

The pronounced dominance of directive acts is not reducible to mere instruction but constitutes evidence of a proactive intervention strategy, whereby the therapist consistently generates communicative stimuli rather than awaiting spontaneous initiation from the child. Within (Skinner, 1948) behavioral framework, each directive operates as a verbal mind that, upon fulfillment, is reinforced through positive feedback; choice-based and investigative questions further cultivate the child's decision-making and reasoning capacities, in accordance with (Paul et al., 2017) principle of clear and repeated instruction.

2. The Implication Use of Assertive Speech Acts

Assertive acts function principally as instruments of language modeling and cognitive correction rather than as neutral factual reporting. Immediate corrective feedback cultivates accurate tacking, that is, the capacity to label objects and events appropriately, while assertive explanations that link behavior to consequence facilitate the child's acquisition of rudimentary causal reasoning.

3. The Implication Use of Expressive Speech Acts

Notwithstanding their comparatively low frequency, expressive acts such as praise constitute a vital mechanism of positive social reinforcement, increasing the probability that praised behavior will recur (Skinner, 1948). Functioning as relational scaffolding, expressives transform the therapeutic encounter into a psychologically secure interaction, thereby enabling the child's willingness to undertake communicative risk.

4. The Implication Use of Commissive Speech Acts

Despite their marked rarity, commissive acts assume a pivotal function in establishing explicit behavioral contingencies. Conditional promises bind the therapist to a prospective action contingent upon the child's compliance, whereas refusals constitute deliberate commitments to non-intervention intended to foster autonomy rather than indices of disengagement. Collectively, whereas Searle's taxonomy elucidates 'what' the therapist articulates, the reinforcement perspectives of Paul and Skinner illuminate 'why' and 'how' such utterances function therapeutically.

5. Comparison with Classroom Teacher Communication

A further point of interest is the fundamental difference between the communication strategies of a therapist and those of a classroom teacher, despite both relying dominantly on directive and assertive acts. A speech therapist functions as a behavior architect, whose words serve as precise intervention tools to build or improve an individual's communication skills through communication that is intensive, repetitive, and aimed at eliciting specific responses. This contrasts with a classroom teacher, who functions as a knowledge facilitator whose speech serves as an efficient instructional tool for conveying material to a larger group and managing classroom dynamics, with a communicative focus oriented toward content delivery and collective task management rather than in-depth individual behavioral intervention (Puspita, 2023).

CONCLUSION

This study analyzed 520 therapist utterances during speech delay therapy sessions using Searle's illocutionary act taxonomy, yielding two major findings. First, four of five illocutionary act categories were actively deployed: directives (363; 69.8%), assertive (125; 24.0%), expressive (29; 5.6%), and commissive (3; 0.6%), while declaratives were entirely absent. The dominance of directives reflects the proactive intervention imperative of speech delay therapy, while assertive, expressive, and commissive each contributed distinct but complementary therapeutic functions. Second, the therapist's communication strategies form an integrated holistic architecture in which the therapist simultaneously acts as initiator, language model, emotional architect, and behavioral manager, deploying each illocutionary type as a precisely calibrated tool rather than incidental speech.

These findings contribute to pragmatic research in clinical settings by demonstrating that speech act theory provides a productive analytical lens for understanding the micro-level communicative mechanisms of professional speech therapy. Practically, the identified strategies offer a framework that therapists can use for reflective practice and that parents can adapt for home-based language stimulation, including using simple commands, asking choice-based questions, modeling correct pronunciation without harsh correction, and giving sincere praise for every communicative effort. Future research should examine the full two-way interaction dynamics by analyzing children's verbal responses alongside therapist utterances, incorporate nonverbal data such as gesture and intonation, and conduct longitudinal studies to track relationships between specific illocutionary act patterns and developmental outcomes over time.

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