
Framework for Defining Cause and Effect in Complex Systems

*Why We Fail at Root Cause Analysis,
How Critical Thinking Fixes It,
and the Formal Tools That Catch What Intuition Misses*

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1 Introduction

Understanding cause and effect in complex systems is crucial for navigating domains where myriad factors interact with feedback loops, delays, and emergent behaviors. A complex system can be defined as a collection of inter-related variables with internal feedback mechanisms, nonlinearities, time-delayed effects, and uncertainties. Unlike simple linear systems, these domains—global economies, material supply chains, innovation ecosystems, military operations, critical infrastructure—exhibit continuous interactions among components, making it challenging to isolate one cause and one effect in the traditional sense.

In such systems, correlations alone are not enough. We need robust methods to infer causality: to discern which changes truly drive outcomes and which are incidental. Yet before we can apply those methods, we must confront a more fundamental problem: **human beings are systematically bad at causal reasoning**. Our cognitive architecture, shaped by evolutionary pressures that rewarded fast pattern-matching over rigorous analysis, consistently leads us to confuse correlation with causation, to accept the first plausible explanation we encounter, and to construct compelling narratives from random noise.

This document presents a detailed, PhD-level framework for defining cause-and-effect relationships in complex systems. It is organized in three layers:

1. **The Cognitive Foundation** (Sections 2–3): Why we fail at causal reasoning, and how critical thinking and first principles discipline provide the mental operating system required to do it correctly.
2. **The Methodological Framework** (Sections 4–5): A nine-step process for identifying and validating cause-and-effect relationships, leveraging causal graphs, simulations, counterfactual reasoning, and probabilistic modeling.
3. **Domain Applications** (Sections 6–8): Worked examples in macroeconomics and cryptocurrencies, graphene and basalt material systems, and AI for scientific discovery and capital allocation.

The framework is computationally and empirically grounded while also allowing for abductive insights—creative hypothesis generation to explain observations beyond straightforward induction. We emphasize techniques to untangle feedback loops, non-linear dynamics, and delayed effects using systems thinking, causal graphs, simulations, counterfactual reasoning, and probabilistic modeling.

So What?

Most failures in complex systems—policy disasters, engineering collapses, investment blowups, intelligence failures—share a common root cause: someone confused a symptom with a cause, or accepted a correlation as proof of causation. The cost of this error, compounded across institutions and decades, is measured in trillions of dollars and millions of lives. This paper provides both the diagnosis and the remedy.

2 Why We Fail: Cognitive Barriers to Causal Reasoning

Before presenting the formal tools for causal analysis, we must answer a prior question: *Why do intelligent, educated, experienced professionals consistently get cause and effect wrong?* The answer lies in the interaction of three domains: individual cognitive biases, the absence of first principles discipline, and institutional structures that amplify both.

2.1 The Cognitive Architecture Problem

The human brain evolved to survive, not to reason correctly about complex systems. The cognitive shortcuts (heuristics) that kept our ancestors alive on the savanna—rapid pattern recognition, threat detection, social inference—are precisely the mechanisms that lead us astray in domains with feedback loops, time delays, and non-linear dynamics. The following biases are not occasional errors; they are the *default mode* of human causal reasoning.

2.1.1 Confirmation Bias: Finding What We Already Believe

Confirmation bias is the tendency to search for, interpret, and remember information that confirms pre-existing beliefs while simultaneously ignoring or discounting disconfirming evidence. In causal reasoning, this manifests as selecting a cause that matches one's prior mental model and then selectively gathering evidence that supports that choice.

Critical Failure Mode

Example: An intelligence analyst who believes a nation-state is developing weapons will interpret ambiguous satellite imagery as confirming that belief. The same imagery, shown to an analyst without that prior, might be interpreted as civilian construction. Both analysts are looking at the same data. Neither is lying. But confirmation bias causes them to construct entirely different causal narratives from identical evidence.

In complex systems, confirmation bias is particularly dangerous because there are always enough variables and correlations to construct a plausible-sounding causal story for almost any hypothesis. The question is never “Can I find evidence that supports this?”—you always can. The question is “Have I genuinely tried to disprove it?”

2.1.2 Narrative Fallacy: The Seduction of Story

Humans are storytelling machines. We compulsively construct coherent narratives from sequential events, even when those events are causally unrelated. Nassim Nicholas Taleb identified this as the *narrative fallacy*: the tendency to create post hoc explanations that impose a causal structure on random sequences.

In financial markets, this manifests daily: “The market fell today because of trade fears” is a narrative imposed on what may be stochastic noise. In post-incident analyses, the narrative fallacy produces neat causal chains that explain the disaster as an inevitable consequence of identifiable failures—when in reality, the system was operating in a regime where many different failure modes were possible, and the one that occurred was not predictable from the information available at the time.

Dinner Table Discussion

Think of it this way: after every plane crash, investigators reconstruct a causal chain that makes the crash seem inevitable. But before the crash, that same chain of events could have produced dozens of different outcomes. The narrative fallacy makes us believe the past was predictable—which makes us overconfident that the future is predictable too.

2.1.3 Availability Heuristic: The Tyranny of the Recent and Vivid

The availability heuristic causes people to weight causes based on how easily examples come to mind, rather than on statistical frequency or causal strength. Recent events, dramatic events, and emotionally charged events are over-weighted. This means that the most *memorable* cause is routinely mistaken for the most *probable* or most *important* cause.

In root cause analysis, this manifests as blaming whatever happened most recently before the failure, rather than investigating the deeper structural conditions that made the failure possible. If a bridge collapses and there was a heavy truck crossing it at the time, the truck gets blamed—even if the real cause was decades of deferred maintenance that left the bridge structurally unsound, where *any* normal load would have triggered failure.

2.1.4 Anchoring: The First Explanation Wins

Anchoring bias causes the first piece of information or the first hypothesis encountered to disproportionately influence all subsequent analysis. In causal investigations, the first explanation proposed—often by the most senior person in the room—becomes the anchor around which all subsequent analysis orbits. Evidence that supports the anchor is accepted; evidence that contradicts it is unconsciously discounted or explained away.

This is particularly destructive in organizational settings where hierarchy influences analysis. When a general, a CEO, or a principal investigator states their initial assessment of what caused a problem, the analytical apparatus of the entire organization often reorganizes itself to confirm that assessment rather than to test it.

2.1.5 Fundamental Attribution Error: Blaming People Instead of Systems

The fundamental attribution error is the tendency to attribute outcomes to individual actions, intentions, or character rather than to systemic conditions. When something goes wrong, we instinctively ask “Who failed?” rather than “What system conditions made failure likely?”

Key Insight

W. Edwards Deming, the father of modern quality management, argued that **94% of problems are caused by systems, not individuals**. Yet in practice, organizations spend 94% of their root cause analysis effort looking for individual failures. This is not a minor calibration error—it is a complete inversion of where analytical effort should be directed.

The fundamental attribution error means that organizations “solve” problems by replacing personnel rather than redesigning the systems that produced the failure. The replacement personnel, operating in the same system, then produce the same failures—and the cycle repeats.

2.1.6 Dunning-Kruger in Causal Reasoning

The Dunning-Kruger effect—where people with limited knowledge in a domain overestimate their competence—is especially pronounced in causal reasoning. Understanding a complex system well enough to identify true causes requires deep expertise, but the less someone understands a system, the simpler it appears to them, and the more confident they are in their causal attributions.

This creates a perverse dynamic in organizations: the people with the least understanding of a system’s complexity are often the most confident in their diagnoses and the most impatient with rigorous analysis. They view careful causal investigation as unnecessary delay rather than as essential due diligence.

2.2 The Death of First Principles Thinking

First principles thinking is the practice of decomposing a problem into its most fundamental, irreducible components—the “ground truths” that cannot be deduced from anything simpler—and then building up an understanding from those foundations. It is the method that Aristotle described, that Descartes formalized, and that drove the scientific revolution.

The opposite of first principles thinking is *reasoning by analogy*: “This looks like that other situation, so the same cause must apply.” Analogy is fast, efficient, and usually approximately correct in simple, stable domains. In complex systems, it is a reliable path to catastrophic error.

2.2.1 Why Analogy Fails in Complex Systems

Reasoning by analogy assumes that surface similarity implies structural similarity. In complex systems, this assumption is routinely violated:

- Two systems can look similar on the surface while having fundamentally different causal architectures (different feedback loops, different delay structures, different non-linearities).
- The same intervention can produce opposite results in two superficially similar systems because of a single structural difference that analogy-based reasoning would never detect.
- Analogies import not just the useful features of the comparison case but also its irrelevant or misleading features, contaminating the analysis with assumptions that were never examined.

Critical Failure Mode

The Iraq/Vietnam Analogy Problem: Every military conflict since 1975 has been analyzed through the lens of “Is this another Vietnam?” The analogy imports assumptions about insurgency dynamics, public opinion trajectories, and escalation patterns that may or may not apply to the actual system under analysis. In some cases, the Vietnam analogy led to useful caution. In others, it prevented necessary action by importing a narrative of inevitable failure that did not match the structural conditions of the actual conflict. First principles analysis—examining the specific causal architecture of each situation—would have produced better decisions in both directions.

2.2.2 The First Principles Method

First principles thinking proceeds in three stages:

1. **Decomposition:** Strip the problem down to its fundamental components. What do we know to be true, independent of convention, analogy, or assumption? What are the physical laws, the verified data, the constraints that cannot be argued away?
2. **Verification:** For each “known” component, ask: How do we know this? Is it measured, assumed, or inherited from a previous analysis? If inherited, has anyone verified it in the current context? Many “root causes” in organizational analyses are actually inherited assumptions that have never been independently verified.
3. **Reconstruction:** Build up an understanding from verified fundamentals. This often produces a causal model that differs significantly from the analogy-based model, because the analogy-based model contained hidden assumptions that do not hold in the current system.

Dinner Table Discussion

Elon Musk popularized first principles thinking in business with the battery cost example: instead of accepting that batteries cost \$600/kWh (the conventional wisdom), he asked what the raw materials cost—about \$80/kWh in 2012. The \$520 gap was not physics; it was the accumulated inefficiency of existing manufacturing processes, supply chain structures, and industry assumptions. First principles revealed that the “cause” of high battery costs was not material constraints (as analogy to other industries suggested) but manufacturing architecture—a completely different causal story with completely different solutions.

2.2.3 Why Organizations Abandon First Principles

Despite its power, first principles thinking is rare in practice because it is slow, cognitively expensive, and socially costly. It requires:

- **Admitting ignorance:** First principles starts with “What do we actually know?” which often reveals that the answer is “Much less than we thought.” This is uncomfortable for experts and threatening to institutional authority.
- **Questioning authority:** Inherited assumptions often come from senior leaders or established frameworks. Questioning them is career risk in most organizations.
- **Tolerating ambiguity:** First principles analysis often produces intermediate states where the answer is “We don’t know yet.” Organizations that reward decisiveness penalize this essential phase.
- **Time investment:** First principles analysis takes longer than analogy-based reasoning. In organizations that confuse speed with competence, this is penalized rather than rewarded.

The result is that most organizations default to reasoning by analogy and call it “experience” or “professional judgment.” The formal tools presented later in this paper are the corrective—but they only work if applied with the first principles discipline described here.

2.3 Institutional and Cultural Amplifiers

Individual cognitive biases are bad enough. Institutional structures routinely make them worse.

2.3.1 Groupthink and Conformity Pressure

Irving Janis's groupthink research demonstrated that cohesive groups systematically suppress dissenting causal explanations in favor of consensus. In causal analysis, this means the first plausible explanation that achieves group acceptance becomes the "root cause" regardless of whether it survives rigorous testing. Dissenting analysts who propose alternative causal models face social pressure to conform, and their alternatives are often dismissed not on evidential grounds but on social ones.

2.3.2 Incentive Structures That Reward Symptoms Over Causes

Most organizations measure and reward the treatment of symptoms rather than the identification and elimination of root causes. Fixing a symptom is visible, fast, and attributable to a specific person. Identifying a root cause is slow, unglamorous, and often implicates systemic conditions that are expensive or politically difficult to change.

Key Insight

A hospital that measures "response time to patient falls" incentivizes fast responses to falls. A hospital that measures "fall rate per 1,000 patient-days" incentivizes understanding why patients fall in the first place. The first hospital will have excellent fall response protocols and a persistent fall rate. The second will have fewer falls. Same problem, but fundamentally different causal orientations driven entirely by what is measured.

2.3.3 The Correlation Dashboard Problem

Modern organizations are awash in data dashboards that display correlations: metrics that move together, trends that appear related, KPIs that seem to predict outcomes. These dashboards are routinely treated as causal models when they are nothing of the sort. A dashboard showing that customer satisfaction scores correlate with revenue growth does not tell you that satisfaction *causes* revenue growth—both might be caused by a third factor (product quality, market conditions, or simply that revenue growth makes companies invest more in customer experience, reversing the assumed causal direction).

The proliferation of data without corresponding investment in causal reasoning has created organizations that are "data-rich and insight-poor"—they have more information than ever but less understanding of what actually causes what.

2.3.4 Authority Bias in Root Cause Analysis

In hierarchical organizations, the causal explanation proposed by the most senior person in the room is disproportionately likely to become the accepted explanation. This is not because senior people are worse at causal reasoning (they may in fact be better, due to experience). It is because the organizational dynamics around their pronouncements suppress the adversarial testing that good causal analysis requires. When the general says "The cause was inadequate intelligence," the staff does not respond with "Actually, sir, let's test that hypothesis against three alternatives." The analysis converges on the authority's initial assessment, and the formal investigation becomes a rationalization exercise rather than a discovery process.

2.4 The Compound Effect: How These Failures Interact

These cognitive, epistemological, and institutional failures do not operate in isolation. They compound:

1. A senior leader proposes an initial causal explanation (**anchoring + authority bias**).
2. The team searches for evidence supporting that explanation (**confirmation bias**).
3. They construct a compelling narrative around the confirming evidence (**narrative fallacy**).
4. Dissenting explanations are suppressed (**groupthink**).
5. The most recent or dramatic events are given causal weight (**availability heuristic**).
6. Individual actors are blamed rather than systemic conditions (**fundamental attribution error**).
7. The “root cause” is declared, symptoms are treated, and the system that produced the failure remains unchanged.
8. The failure recurs.

This sequence is not hypothetical. It describes the post-mortem process in the majority of organizational failure analyses, from military after-action reviews to corporate incident reports to government investigations. Breaking this cycle requires both the cognitive discipline of critical thinking and the formal rigor of the methodological framework presented in the following sections.

3 Critical Thinking as the Operating System for Causal Analysis

If cognitive biases are the bugs in human causal reasoning, critical thinking is the operating system upgrade that patches them. Critical thinking is not a personality trait or an innate talent. It is a *practice*—a set of disciplined habits that can be learned, taught, and institutionalized. This section presents critical thinking as the prerequisite cognitive discipline for the formal causal analysis framework that follows.

3.1 The Hierarchy of Evidence

Not all evidence is created equal. A foundational critical thinking skill is the ability to evaluate the quality of evidence supporting a causal claim. The hierarchy, from strongest to weakest:

1. **Controlled experiments with replication:** Direct manipulation of the proposed cause, with controls, producing consistent effects across multiple trials.
2. **Natural experiments and quasi-experimental designs:** Situations where nature or policy creates variation in the proposed cause that can be exploited for causal inference (instrumental variables, regression discontinuity, difference-in-differences).
3. **Prospective longitudinal studies:** Tracking the proposed cause and effect over time, with measurement of confounders.

4. **Cross-sectional studies with statistical controls:** Observational data with attempts to control for confounding variables.
5. **Case studies and anecdotal evidence:** Individual instances that illustrate a causal pattern but cannot establish it.
6. **Expert opinion without supporting data:** The weakest form of evidence, yet the most commonly used in organizational decision-making.

Dinner Table Discussion

Here is the uncomfortable truth: most “root cause analyses” in organizations are conducted at Level 6—expert opinion—and occasionally reach Level 5—a few case examples. The formal framework in this paper is designed to push analysis toward Levels 1–4, where causal claims can actually be tested rather than merely asserted.

3.2 Socratic Questioning: The Discipline of Interrogation

Socratic questioning is the systematic practice of testing claims by asking probing questions rather than accepting them at face value. Applied to causal reasoning, it takes specific forms:

- **Clarification:** “What exactly do you mean when you say X caused Y? Through what specific mechanism?”
- **Assumption probing:** “What are we assuming about the system that makes this causal claim plausible? Have we verified those assumptions?”
- **Evidence testing:** “What evidence supports this claim? What evidence would disprove it? Have we looked for the disconfirming evidence?”
- **Alternative explanation:** “What other causes could produce the same observed effect? Have we eliminated them?”
- **Consequence testing:** “If this causal claim is correct, what else should we observe? Do we observe it?”
- **Meta-questioning:** “Why are we asking this question in this way? Is our framing biasing the analysis?”

The discipline is in applying these questions consistently, especially when the proposed causal explanation is comfortable, convenient, or championed by authority.

3.3 Steel-Manning: The Obligation to Strengthen Opposing Explanations

The opposite of a straw man argument is a steel man: the strongest possible version of an opposing position. In causal analysis, steel-manning means that for every proposed root cause, the analyst is **obligated** to construct the strongest possible case for an alternative cause before accepting the original.

This is cognitively painful. It requires arguing against your own hypothesis with genuine effort. But it is the single most effective countermeasure to confirmation bias. If the strongest possible case for the alternative explanation fails to match the evidence, confidence in the original explanation

is genuinely warranted—not because you avoided looking at alternatives, but because you defeated them.

3.4 Necessary vs. Sufficient Conditions

A critical distinction that is routinely collapsed in causal analysis:

- A **necessary condition** must be present for the effect to occur, but its presence alone does not guarantee the effect. Oxygen is necessary for fire but does not cause fire.
- A **sufficient condition** guarantees the effect when present, but the effect may also occur from other causes. A lightning strike is sufficient to start a fire but is not the only possible ignition source.
- Most causal explanations in complex systems involve conditions that are **neither individually necessary nor individually sufficient**—they are *contributory* causes that increase the probability of the effect in combination with other factors.

Confusing necessary with sufficient conditions—or treating contributory causes as if they were individually sufficient—is one of the most common errors in root cause analysis. When an investigation identifies “human error” as the root cause, it has typically identified a contributory factor (a necessary condition in that specific instance) and treated it as if it were a sufficient explanation. The systemic conditions that made the error consequential—the lack of redundancy, the absence of error-trapping mechanisms, the design that permitted a single point of failure—are the deeper necessary conditions that the analysis should have targeted.

3.5 The Five Whys: Power and Limitations

The “Five Whys” technique—asking “Why?” iteratively to drill from symptoms to root causes—is widely taught in quality management and lean manufacturing. It has genuine value as a starting discipline for moving analysts past surface-level explanations. However, it has significant limitations in complex systems:

- **Linear chain assumption:** The Five Whys assumes a single causal chain. Complex systems have multiple interacting causes, feedback loops, and branching causal pathways. Drilling down a single chain can miss the interaction effects that are the actual root cause.
- **Anchoring to the first “Why”:** The first answer to “Why did this happen?” anchors the entire subsequent chain. A different initial answer would produce a completely different chain, potentially arriving at a different “root cause.”
- **No stopping rule:** There is no principled reason to stop at five iterations rather than three or twelve. The “root cause” is often wherever the analyst runs out of patience or knowledge.
- **Absence of validation:** The Five Whys produces a hypothesis, not a verified cause. Without testing the proposed root cause (e.g., by showing that eliminating it prevents recurrence), the analysis remains speculative.

The Five Whys is best used as a brainstorming tool to generate candidate causes, not as a conclusive analytical method. The formal framework in this paper provides the validation apparatus that the Five Whys lacks.

3.6 Mapping Critical Thinking to the Causal Analysis Framework

Each step of the nine-step methodological framework (Section 5) requires a specific critical thinking discipline. Table 1 maps these correspondences:

Table 1: Critical Thinking Disciplines Mapped to Framework Steps

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| 1. Define Boundaries | Resist scope bias; question why the boundary is drawn here and not elsewhere | <i>Anchoring, framing effects</i> |
| 2. Data Gathering | Seek disconfirming data as actively as confirming data | <i>Confirmation bias</i> |
| 3. Hypothesis Formation | Generate multiple competing hypotheses; steel-man each | <i>Narrative fallacy, anchoring</i> |
| 4. Causal Graph | Include feedback loops and systemic factors, not just individual-level causes | <i>Fundamental attribution error</i> |
| 5. Non-linearity & Delays | Question linear assumptions; look for threshold effects | <i>Availability heuristic</i> |
| 6. Simulation | Test hypotheses against virtual experiments, not just intuition | <i>Overconfidence, Dunning-Kruger</i> |
| 7. Validation | Actively attempt to falsify, not just confirm | <i>Confirmation bias</i> |
| 8. Counterfactuals | Ask “What else could have caused this?” at every stage | <i>Narrative fallacy</i> |
| 9. Continuous Refinement | Remain willing to discard prior conclusions when new evidence warrants it | <i>Anchoring, sunk cost</i> |

So What?

The formal tools of causal analysis—DAGs, simulations, Bayesian networks, counterfactual reasoning—are powerful. But they are only as good as the thinking that feeds them. If the analyst constructs the causal graph while under the influence of confirmation bias, the graph will encode the bias, the simulation will amplify it, and the “validated” result will be a rigorous-looking confirmation of a wrong answer. Critical thinking is not a soft skill bolted onto the methodology. It is the **prerequisite operating system** without which the methodology produces sophisticated-looking garbage.

4 Challenges in Establishing Causality in Complex Systems

With the cognitive and critical thinking foundations established, we now examine the structural properties of complex systems that make causality objectively difficult to determine, even for disciplined analysts.

- **Numerous Interdependent Variables:** Complex systems involve a large number of interconnected components. For example, cryptocurrency markets are influenced by technology adoption, investor sentiment, regulatory changes, global liquidity, and more. Changes in one

factor ripple through many others, making isolation of any single cause-effect pair inherently difficult.

- **Feedback Loops (Circular Causality):** Unlike a one-way causal chain, complex systems often have circular causation where effects loop back to influence their own causes. A policy change might alter behavior in a way that eventually feeds back into policy needs. Such circular causal structures widely exist in complex dynamical systems—a variable may affect itself through a chain of influences forming closed loops. This violates the assumptions of traditional acyclic causal models and makes analysis challenging.
- **Non-linearity:** Relationships in complex systems are often non-linear. Small changes can have disproportionately large effects and vice versa. For instance, adding a small amount of graphene to concrete dramatically increases its strength (non-linear improvement), allowing a large reduction in cement usage. Non-linear responses mean we cannot assume effects scale in proportion to causes—we must consider threshold effects, tipping points, and diminishing or compounding returns.
- **Time Delays:** Effects of a cause may not manifest immediately. Changes in one part of a system may take time to propagate, creating oscillations or overshoot behavior. For example, a change in interest rate policy might influence inflation or investment only after several quarters. Accounting for lagged effects is essential to avoid mistaking a delayed cause for no cause at all.
- **Emergent Patterns:** Complex systems often exhibit emergence—coherent patterns at a macro-level not obvious from micro-level parts. Market cycles, crowd behaviors, and material phase transitions are examples. Emergent phenomena can appear to have their own macro-level cause-effect structure (“downward causation”). We must be open to multi-level causation.
- **Unintended Consequences:** Intervening in a complex system can lead to unexpected outcomes. Thanks to the intricate web of interactions, a policy or innovation may produce side-effects that were not part of the initial causal reasoning. Systems thinking teaches that well-intentioned actions can generate counterintuitive results if feedback loops or hidden pathways were overlooked.

Given these challenges, combined with the cognitive barriers identified in Section 2, our approach uses a systems thinking mindset combined with rigorous data analysis and modeling. The critical thinking disciplines from Section 3 serve as the cognitive foundation; the formal methodology that follows provides the analytical architecture.

5 Methodological Framework for Causal Analysis in Complex Systems

We outline a nine-step framework for identifying and validating cause-and-effect relationships in complex systems. This framework moves from initial conceptualization through computational modeling to ongoing refinement, ensuring both empirical grounding and space for theoretical insight. Each step requires the critical thinking disciplines mapped in Table 1.

5.1 Step 1: Define System Boundaries and Objectives

Begin by clearly defining the system of interest and the question you want to answer. Complex systems can extend indefinitely, so it is critical to set boundaries that make analysis tractable while including all important factors. Identify the key entities, variables, and processes relevant to your cause-effect inquiry.

Critical thinking check: Apply Socratic questioning to the boundary itself—why here and not wider or narrower? What are you assuming by excluding certain variables? The boundary definition is itself a causal hypothesis (that excluded factors do not significantly influence the outcome).

Techniques: Create a conceptual map or influence diagram listing all candidate variables and links based on literature and expert knowledge. Engage domain experts in brainstorming sessions to ensure no major element is omitted. At this stage, err on the side of inclusion. Identify external factors treated as given (exogenous) versus those within the system (endogenous). Also consider the time scale of interest and ensure the system boundary spans the relevant timeframe.

5.2 Step 2: Data Gathering and Empirical Grounding

Gather all available data that can inform relationships among the variables. This step makes the analysis empirically grounded: ensuring causal hypotheses can be backed by real-world evidence or measurements. Depending on the domain, data may include time-series measurements, experimental results, case studies, or expert surveys.

Critical thinking check: Are you gathering data that could *disprove* your hypotheses as actively as data that could confirm them? If your data collection is guided by your hypothesis, you will find what you are looking for regardless of whether it is true.

It is often necessary to integrate heterogeneous data sources. A comprehensive framework for analyzing crypto’s macrofinancial linkages, for example, requires “appropriate granular data across sectors and tools, in addition to information on the legal and regulatory status of crypto assets.” Ensure the data spans sufficient history to capture different regimes. Pay attention to data quality and comparability. Crucially, incorporate qualitative observations from experts or stakeholders, formalized via Delphi studies or interviews.

5.3 Step 3: Hypothesis Formation (Abductive Reasoning)

Using the system map and data, formulate initial hypotheses about cause and effect. In complex systems this often requires abductive reasoning—inferring the most likely explanations for patterns observed, even if they cannot yet be rigorously proven. Abduction complements induction and deduction in domains with incomplete information.

Critical thinking check: For every hypothesis you propose, construct the steel-man version of at least one alternative explanation. If you cannot generate plausible alternatives, you do not understand the system well enough to identify the actual cause.

List plausible cause-effect pairs and multi-step causal chains. Include potential feedback loops in hypothesis form. Abductive reasoning allows creative leaps that can later be tested. Maintain a healthy balance between theory-driven hypotheses (grounded in established knowledge) and data-driven hypotheses (suggested by patterns). Apply the first principles method from Section 2.2: decompose the system to verified fundamentals before accepting inherited causal explanations.

5.4 Step 4: Construct a Causal Graph or Diagram

Translate hypotheses into a visual and formal causal model, typically a **causal loop diagram** (CLD) or a **directed acyclic graph** (DAG). Map variables as nodes and causal influences as arrows, labeling feedback loops and delays explicitly. CLDs provide a holistic view of the system, allowing anticipation of potential unintended consequences and identification of leverage points.

Critical thinking check: Does your causal graph include systemic and structural causes, or only individual-level causes? If the graph assigns causation primarily to people rather than systems, revisit the fundamental attribution error discussion in Section 2.

Mark the polarity of relationships (+ for positive correlation, – for inverse). Identify reinforcing loops (which can amplify growth or decline) and balancing loops (which counteract changes). Developing the causal graph often reveals gaps or overly complex regions. Simplify where possible by aggregating variables, but preserve the core feedback structure. As part of this step, identify what data support exists for each link and mark confidence levels.

5.5 Step 5: Incorporate Non-linearity, Delays, and Uncertainty

Augment the causal model to handle non-linear relationships, time delays, and uncertainty explicitly:

- **Non-linear Relationships:** For each causal link, consider the functional form. Does the effect saturate? Are there threshold effects? Represent these in the model using non-linear formulas, lookup tables, or piecewise logic.
- **Time Delays:** Indicate delays on specific links. Implement delays via buffers or differential equations with time constants. Recognize that delays can create oscillatory modes.
- **Uncertainty and Variability:** Assign probabilistic elements where appropriate. Specify coefficients as distributions rather than fixed numbers. Techniques include Bayesian causal networks—which “combine causal reasoning and probabilistic reasoning, making them a powerful tool for modeling complex systems”—and Monte Carlo simulations.
- **Feedback Loop Gains:** Estimate loop strength. If a reinforcing loop gain is ≥ 1 , it can lead to runaway growth or oscillation; if < 1 , it will eventually saturate.

By the end of this step, the causal model is not just a static diagram but a dynamic hypothesis with formulas for how changes propagate, an account of timing, and acknowledgment of uncertainty.

5.6 Step 6: Simulation and Dynamic Analysis

Simulate the system’s behavior under various scenarios. Simulation serves as a “virtual experiment”—especially useful when real-world experiments are infeasible. Methods include:

- **System Dynamics Simulation:** Convert the CLD into differential equations. Simulate time trajectories under various shocks.
- **Agent-Based Modeling (ABM):** If individual heterogeneity or network effects are key, simulate many agents with individual decision rules and observe emergent macro-level patterns.
- **Probabilistic Simulations (Monte Carlo):** Incorporate uncertainty by running many iterations with random parameter draws. This yields distributions of outcomes rather than

point estimates.

- **Counterfactual Scenario Analysis:** Deliberately simulate counterfactuals—change a potential cause and observe the effect. This is akin to the *do*-operator in Pearl’s causal inference framework: $do(X) = x$ and observe Y .

During simulation, pay attention to emergent behaviors or surprises. Use phase diagrams or parameter sweeps to map tipping points. If the simulation shows something counter-intuitive, revisit assumptions—it could reveal a new insight or indicate a model error.

5.7 Step 7: Validation of Causal Hypotheses

Validate that cause-and-effect relationships are realistic and supported by evidence. Validation occurs on multiple levels:

- **Structural Validation:** Does the model structure match known real-world causal structures? Consult domain experts.
- **Quantitative Fit:** Compare model outputs to historical data not used in building the model.
- **Causal Inference on Data:** Apply formal statistical causal inference techniques—Granger causality tests, instrumental variable regression, difference-in-differences—to test specific links.
- **Expert Review and Case Studies:** Present reasoning to experts for critique. Check against documented case studies.

Critical thinking check: Validation is where confirmation bias is most dangerous. The question is not “Does the model fit the data?” (it almost certainly will, given enough parameters). The question is “Does the model fail when it should fail?” A model that confirms everything confirms nothing.

5.8 Step 8: Counterfactual Reasoning and Sensitivity Analysis

Use the validated model to explore “what-if” scenarios. Counterfactual reasoning asks: if X had been different, how would Y change? This is the essence of causal thinking.

- **Intervention Experiments:** Set a variable to a certain value and observe outcomes, holding other drivers constant.
- **Policy Simulations:** Simulate complex interventions affecting multiple parts of the system. Track multi-step effects and unintended consequences.
- **Sensitivity Analysis:** Vary assumed parameters to determine which causal conclusions are robust versus fragile.
- **Probabilistic Counterfactuals:** Using Monte Carlo runs, compute probabilities: “If we intervene to do X , what is the probability Y increases?”

By engaging in counterfactual reasoning, you interrogate the causal model, strengthening confidence that $X \rightarrow Y$ holds as a causal claim and understanding its limits.

5.9 Step 9: Continuous Refinement and Learning

Complex systems are dynamic and evolving. Defining cause and effect is not a one-off task but an ongoing process of learning and refinement:

- **Monitoring and Data Updates:** Keep collecting data. Update model parameters with the latest information.
- **Model Revision:** Revise structure when warranted by new feedback loops or changed system dynamics.
- **Validation Cycles:** Continuously validate against real outcomes. Did the cause-effect prediction hold?
- **Incorporate Abductive Learnings:** Allow room for new hypotheses when the model cannot fully explain observations.
- **Communication and Stakeholder Feedback:** Gather feedback from decision-makers who use the model's insights. Their real-world experience provides additional validation or reveals missing factors.

The framework becomes a living model of the system's causality. Each cycle of data \rightarrow hypothesis \rightarrow model \rightarrow test \rightarrow data strengthens causal knowledge. This approach recognizes that in complex systems, defining causality is iterative—we progressively approximate the true causal structure, never perfect but improving over time.

6 Domain Application: Macroeconomics and Cryptocurrencies

To illustrate the framework, consider the complex system of macroeconomics intertwined with the cryptocurrency ecosystem. This domain exemplifies many challenges: global feedback loops, regulatory and market non-linearities, and evolving structures.

System Definition: The system includes major macroeconomic factors (global interest rates, inflation, capital flows, exchange rates), crypto markets (price, adoption rates, mining activity, stablecoin supply), traditional financial sector linkages (banks, payment systems), and relevant sociopolitical elements (regulatory actions, public trust in fiat). The question: “How do shifts in global liquidity affect cryptocurrency markets, and could widespread crypto adoption in turn impact traditional macroeconomic stability?”

Data Gathering: Historical data on central bank policy rates, money supply (M2), inflation rates, and GDP growth, alongside crypto-specific data—prices, trading volumes, active wallets, mining hash rate. Capital flows data, regulatory event timelines coded as variables, and institutional quality indices (Economic Freedom Index, Corruption Perceptions Index).

Hypothesis Formation: (a) Loose monetary policy drives crypto prices via liquidity-seeking behavior. (b) In economies with capital controls or high inflation, crypto adoption enables capital flight, potentially creating a reinforcing spiral of currency depreciation and adoption. (c) Regulatory crackdowns may initially depress markets but reduce long-term financial stability risks—though potentially driving activity underground. (d) Crypto market shocks can transmit to traditional finance via institutional balance sheet exposure.

Causal Mapping: Key variables include Global Interest Rate, Investor Risk Appetite, Crypto Price, Crypto Adoption Rate, Fiat Currency Stability, Regulatory Severity, and Financial Institution Exposure. Reinforcing loops include the Liquidity Cycle (low rates \rightarrow borrowing \rightarrow crypto inflows

→ price rises → wealth effect → more investment) and the Institutional Adoption loop (higher market cap → institutional participation → legitimization → further demand). Balancing loops include the Regulatory Response (growth triggers restrictions that dampen demand). The Macro Hedge loop (economic instability → crypto adoption → weakened local currency → more instability) represents a potentially destabilizing reinforcing feedback.

Non-linearity and Uncertainty: The interest rate–crypto price relationship is non-linear with threshold effects. Regulatory impact is also non-linear (mild reporting requirements versus outright bans produce very different responses). Bayesian updating refines parameter estimates as new rate cycles provide data.

Simulation: System dynamics models simulate scenarios: a sustained high-interest regime (5%+ rates for years) showing crypto market stagnation; a coordinated crypto crash showing balance sheet contagion to banks and mild economic contraction; policy scenarios comparing strict prohibition versus regulated integration.

Validation: Model outputs compared to the 2020–2021 boom (zero rates plus stimulus) and 2022 cooling (rate hikes). Cross-sectional validation against high-inflation countries (Argentina, Turkey, Venezuela) where crypto adoption surged. Granger causality tests on M2 and Bitcoin prices.

Counterfactual Reasoning: What if central banks tightened earlier? What if a major economy adopted Bitcoin as legal tender? What if crypto did not exist—would people in currency crises find alternative hedges? Could a crypto crash trigger a wider financial crisis at current exposure levels?

Continuous Refinement: The landscape evolves with new regulations, CBDCs, evolving correlations with equities, and the emergence of stablecoins as a crucial node linking crypto and traditional money markets.

So What?

The framework reveals that liquidity conditions causally drive crypto market cycles, and crypto adoption can in turn undermine or bypass traditional monetary controls, creating novel feedback loops between the financial system and the real economy. This is not speculation—it is a testable causal architecture that can be refined as data accumulates.

7 Domain Application: Graphene and Basalt Material Systems

We apply the framework to material science and engineering systems, focusing on how innovations like graphene and basalt fibers propagate effects through engineering applications, supply chains, and environmental systems.

System Definition: The system includes the materials innovation as trigger, followed by cascading effects through material performance (mechanical strength, durability, battery capacity), engineering usage (construction techniques, product designs), supply chain (production of graphene or basalt, raw resource needs, manufacturing processes), and broader impacts (cost, adoption rates, carbon emissions, infrastructure lifecycle). Feedbacks include how adoption changes costs and how supply constraints moderate adoption.

Data Gathering: Laboratory results on graphene-enhanced concrete (strength gain per percentage of graphene), cement and steel production data (costs, emissions per ton), basalt fiber production data (capacity, cost per kg, energy requirements), pilot project performance, CO₂ emissions data for cement (~8% of global emissions), battery performance data, historical adoption rates of analogous innovations (epoxy-coated rebar, fly ash in cement), and qualitative input on barriers to adoption.

Hypothesis Formation: (a) Graphene addition enables major reductions in cement and steel usage—one study found a 16.5% strength increase with an associated 12.8–15.9% reduction in cement CO₂ emissions, and another achieved up to 50% cement reduction. (b) Basalt fiber reinforcement extends structure life and reduces maintenance because basalt fibers do not corrode like steel. (c) A reinforcing learning curve loop: more adoption → more production → lower cost → further adoption. (d) Net CO₂ reduction if the production emissions of additives are offset by larger savings in cement/steel and extended life.

Causal Mapping: Nodes include Graphene Content, Concrete Strength, Required Cement Volume, Steel Reinforcement Need, Construction Cost, CO₂ Emissions, Adoption Rate, Graphene Production Cost, Basalt Fiber Usage, Structure Lifespan, and Maintenance Demand. Reinforcing loops include Performance → Adoption → Cost → Adoption and the environmental benefit loop (reduced cement → lower CO₂ → green incentives → further adoption). Balancing loops include supply constraints limiting adoption speed.

Non-linearity: Strength gain from graphene is non-linear with an optimal percentage; adoption curves are S-shaped (logistic); building code approval introduces 5–10 year delays.

Simulation: A 20-year scenario where graphene concrete is gradually introduced projects market share, cement demand reduction, and CO₂ impact. Sensitivity to graphene production capacity reveals whether supply constraints could temporarily slow adoption. For basalt, lifecycle simulation shows that bridges with basalt rebar lasting 50 years versus 30 years with steel rebar accumulate massive savings in materials and maintenance over a century.

Validation: Comparison with real trials (e.g., UK “Concretene” graphene concrete achieving significant cement reduction), analogous innovation diffusion rates, and life-cycle analysis studies showing 13%+ CO₂ reduction potential.

Counterfactual Reasoning: What if graphene production capacity doubled by 2025? What if a carbon tax made traditional cement more expensive? What if basalt fiber completely replaced steel rebar—how would this affect steel industry demand and construction cycles?

So What?

Using graphene in concrete clearly causes higher strength and reduced cement/steel needs, which in turn causes a measurable drop in CO₂ emissions. Using basalt fiber causes greater durability and less maintenance, which over time causes cost savings and waste reduction. These causal links live within a network of economic and supply feedbacks that the framework maps and models.

8 Domain Application: AI for Scientific Discovery and Capital Allocation

We examine how AI systems influence scientific discovery processes, funding decisions, and human collaboration in research—a socio-technical system where cause and effect span technology, human behavior, and institutional structures.

System Definition: The system includes AI tools (algorithms for literature review, hypothesis generation, project evaluation), scientists and decision-makers (researchers, grant reviewers, venture capitalists), and institutions (funding agencies, universities, corporate R&D). The question: “In what ways can AI systems, when introduced into the research and funding ecosystem, causally improve discovery and decision-making, and what new feedback loops does this create?”

Data Gathering: Historical funding data (proposals, success rates, topic diversity), publication and discovery metrics (papers, citation impact, time to breakthroughs), patent rates in fields with heavy AI use versus without, performance data from AI-assisted investment screening, case studies of AI in scientific discovery (e.g., AlphaFold’s impact on structural biology), collaboration network data, and survey data from scientists on AI trust and workflow changes.

Hypothesis Formation: (a) AI in funding leads to more optimal resource allocation with higher success rates and less bias. (b) AI-driven analysis increases the rate or quality of scientific discoveries. (c) AI leads to more interdisciplinary collaboration by bridging knowledge gaps. (d) AI-driven funding creates a feedback loop where certain research areas get amplified, potentially creating a self-fulfilling prophecy that could be beneficial (picking winners) or harmful (locking in conventional thinking).

Causal Mapping: Key variables include AI System Capability, Funding Decision Quality, Research Output, Research Diversity, Human Collaboration Intensity, Bias in Decisions, and Feedback Data. Important loops include: human trust in AI (good recommendations → more trust → more use, a reinforcing loop); the self-reinforcing data loop (AI funds areas → those areas produce output → output trains the AI → AI favors those areas more); and the potential homogenization loop (broad AI adoption → similar recommendations everywhere → reduced diversity of approaches).

Non-linearity and Uncertainty: Threshold effects in AI capability (below a certain performance level, humans ignore AI suggestions; above it, adoption is rapid). Diminishing returns in decision quality improvement. Long delays between funding decisions and observable research outcomes. High uncertainty in estimating AI’s impact on discovery rates.

Simulation: Simulate a research ecosystem with cohorts of proposals, varying true quality, evaluated by human panels versus AI-assisted versus AI-autonomous processes. Track discoveries, diversity of funded fields, and whether AI-assisted selection outperforms pure human evaluation. Model adaptive applicant behavior (researchers optimizing proposals for AI criteria—a Goodhart’s Law dynamic).

Validation: Compare with real examples of AI in drug discovery (AI-designed molecules entering trials faster than traditional methods), AlphaFold’s acceleration of structural biology research, and any pilot programs in AI-assisted grant review. Validate sub-components: can AI trained on past grant data predict which funded projects will succeed?

Counterfactual Reasoning: What if a major funding agency fully adopted AI-assisted decision-making? Would researchers game the system? Would AI democratize research by giving small

institutions access to analytical power previously available only to elite labs? Or would it concentrate advantage in labs with the best AI systems?

So What?

AI assistance should cause more data-driven, less biased decision-making in funding, and AI tools can accelerate discovery and enable wider collaboration. However, the framework reveals important feedback loops—including the risk that AI-driven funding creates self-reinforcing concentration in certain research areas—that require oversight and design safeguards. The best outcome is hybrid: AI and human strengths combined, with monitoring of diversity metrics as a feedback signal.

9 Conclusion

Across these diverse domains—macroeconomics and crypto, advanced materials, and AI in science—the process of clearly defining cause and effect in complex systems follows a coherent framework built on three layers.

First, the cognitive foundation. We must recognize that human beings are systematically poor at causal reasoning due to cognitive biases (confirmation bias, narrative fallacy, availability heuristic, anchoring, fundamental attribution error) that are amplified by institutional structures (groupthink, incentive misalignment, authority bias, correlation-dashboard thinking). The remedy is the disciplined practice of critical thinking—first principles decomposition, Socratic questioning, steel-manning alternative explanations, and rigorous application of the hierarchy of evidence—applied at every step of the analytical process.

Second, the methodological framework. The nine-step process—from system definition through simulation to continuous refinement—provides the formal architecture for causal analysis. Methods like causal loop diagrams visualize the web of interactions. Systems simulations reveal dynamic behavior (tipping points, oscillations, nonlinear responses). Counterfactual analysis sharpens understanding of what factors truly drive changes. Probabilistic modeling handles uncertainty. Each step is paired with specific critical thinking disciplines that prevent cognitive biases from contaminating the formal analysis.

Third, the domain applications. The framework is not theoretical—it produces actionable causal models. For macroeconomics and crypto, it illuminates how policy and digital innovation co-influence each other in feedback loops. For graphene and basalt materials, it connects micro-scale properties to macro-scale sustainability impacts. For AI in science, it shows how a new tool can reshape human enterprise via multiple direct and indirect paths.

The framework is empirically grounded yet welcomes abductive leaps. It is computationally rigorous yet begins with the recognition that no formal tool can compensate for undisciplined thinking. It is comprehensive yet iterative, recognizing that in complex systems, causal understanding is never final but progressively refined.

Key Insight

The central thesis of this paper: **Every catastrophic failure of causal reasoning—in policy, in engineering, in intelligence, in investment—can be traced to a failure at one of these three layers.** Either the analyst’s cognitive biases went unchecked, or the formal methodology was absent or inadequate, or the results were not iteratively validated against reality. Fix all three layers, and you do not eliminate error—complex systems are too complex for that—but you reduce the frequency and severity of causal reasoning failures by orders of magnitude.

In essence, this framework creates a living causal model of the system that improves over time—much like science itself, continually refining its understanding of cause and effect in our complex world.

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