orders can be very challenging. A free talk about her sexual life and its problems may develop into an uncomfortable discussion for both the doctor and the patient. Personal taboos regarding sex, confidentiality issues, worries about potential humiliation, time constraints, even the doctor’s limited experience in handling sexual problems, are a few of the factors that can impede the uncovering of possible sexual difficulties or disorders. Moreover, since many of the causes of FSD do not have a strict medical origin, one has to be careful when characterizing all woman’s sexual problems as organic, as this can lead to mistaken diagnoses and further complicate their management.

To identify whether a diabetic woman has sexual dysfunction and prescribe appropriate treatment, factors that contribute to sexual dysfunction, such as the woman’s current interpersonal and psychosocial status, her sexual and medical history, comorbid illness as well as her medication should be examined. Sexual dysfunction can be a symptom of an underlying disorder or have causes outside the patient herself. To begin with, a thorough general medical history is essential. The physician should be aware not only of the duration of diabetes, the glycemic control, the presence or absence of chronic diabetic complications, the pharmacological treatment of diabetes but mainly the mood of the diabetic woman as this is the key to the whole process of her sexual enjoyment. Even minor episodes of depression can affect the woman’s sexual desire. Poor diabetic control or diabetic complications may cause depression and thus sexual dysfunction in women with diabetes. Hypoglycemia can also impair sexual function in a diabetic woman, as arousal, foreplay, intercourse, and orgasm are all activities of energy expenditure. Comorbid factors, history of surgical operations, medication use, menopausal status, personal habits such as smoking, alcohol intake, and type of exercise can provide useful information on the possible risk factors. During the general systems enquiry, questions about sexual function can follow the gynecological history. If a woman acknowledges sexual problems, a detailed interview of her and her partner both individually and together is usually necessary. The age of initiation of sexual activity, enquiries about sexual abuse or other traumatic sexual experiences, number of sexual partners, impact of religious and social beliefs on sexuality should be taken into account. Moreover, information about the couple’s current sexual life, practices, and complaints along with the degree of satisfaction that results from the sexual activity should be obtained.

In order to facilitate medical practice in the field of sexual medicine, several tools that estimate female sexual function have been developed. To assist physicians in the initial approach and evaluation of sexual function, two simple models have been proposed, namely ALLOW and PLISSIT (Table 2). For a more detailed and extensive evaluation, structured interviews and self-reported validated questionnaires are the most commonly used methods. Structured interviews have a more personal character as they provide the opportunity for clarifying possible details, answering questions, and explaining terms; moreover, the physician has the chance to evaluate the patient’s reactions during the interview. Validated questionnaires on the other hand are characterized by privacy and confidentiality, are adjusted to the female population, and can include measurable data that can be further analyzed. The Female Sexual Function Index (FSFI), the Brief Index of Sexual Functioning for Women (BISF-W), the Derogatis Interview for Sexual Function (DISF/DISF – SR) and the Female Sexual Distress Scale (FSDS) are some of the available questionnaires that evaluate female sexual function and its disorders. Nevertheless, because of the complexity of the female sexual function, resistant cases of FSD require a multidisciplinary approach, preferably conducted by appropriately trained physicians and specialists.

### Table 2. Available models for evaluating sexual function

#### The ALLOW model
- Ask about sexual life
- Legitimize sexual problems
- Set limitations regarding sexual medicine practice
- Open up the discussion
- Work together to treat

#### The PLISSIT model
- Permission to discuss sexual problems
- Provide limited information regarding sexuality
- Provide specific suggestions on the reported problems
- Refer for intensive treatment by a specialist